DOCUMENTS OF THE NEW MEDICINE

Summary of the New Medicine

(Updated to 2000)

Presentation to comply with the qualification as lecturer of 1981, at the University of Tübingen

by
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THE ABRIDGED NEW MEDICINE

presented to the University of Tübingen as a Lecture Thesis in 1981 and completed in 2000

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Dr Ryke Geerd HAMER

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1 Foreword

When I discovered the 'Iron Rule of Cancer' and the two-phased nature of disease in 1981, I submitted my work as a thesis to the University of Tübingen in the belief that I had discovered the connections linking all cancers. It was two years later, during the course of my ongoing research that I noticed that all diseases behaved in accordance with these two biological laws and not just carcinomas.

In 1987, I discovered the third and fourth biological laws based on embryology and the behavioural sciences. To my surprise, I was able to establish that these four biological laws can explain all diseases and can be reproduced in each individual case. This forced me to a breathtaking conclusion:

That there is obviously a biological meaning in the diseases of the different germ layers and that they are not meaningless mistakes of nature that we should fight, but instead, are very meaningful events. I therefore had to ask myself:

- What brought this disease about? (How?)
- What is its biological meaning? (Why?)

I understood that it would only be possible to find the meaning of diseases by referring to the science of embryology and that the biological-social context should also be taken into account in this biological understanding of meaning. E.g., a mother becomes ill for the benefit of her child or her partner!

I finally had to ask myself whether our understanding and our concept of disease had not been entirely wrong because of our not knowing about the biological purpose of diseases.

I was able to prove that the biological reason for diseases depended on the germ layers (Chapters 'The Diseases of the Germ Layers'). For example, the reason for diseases of the organs of the inner germ layer (endoderm) lies in the conflict active phase (first phase). In contrast, the biological reason for diseases affecting organs controlled by the cerebral-medulla lies in the conflict resolution (second phase).

I ended up with an entirely different nosological understanding of the concept of 'disease'. We can no longer really speak of it in its earlier sense, but instead, should call it 'an intentional program of nature'.

The DHS (Dirk-Hamer-Syndrome) is the first, meaningful event that triggers this special program.

This summary of my thesis is to make the process of nosological understanding clear and to explain the biological meaning of so-called diseases.

'Disease', in a natural-science-nosological sense, is a teleologically comprehensible, meaningful biological occurrence, a 'special program of nature'.

2 The NEW MEDICINE as a natural science discipline with five biological laws

I should like to explain what I mean when I speak of NEW MEDICINE as opposed to 'old medicine'.

The NEW MEDICINE understands the body as a unified organism, a unity, with the psyche being the integrator of all functions of behaviour and all areas of conflict, and the brain being the main computer of all behavioural functions, conflict areas and organs, and the sum of the consequences of all these events.

It is more complicated in reality because the computer brain programs the programmer (psyche) and therefore itself.
The NEW MEDICINE is a natural science, based on five empirically discovered laws that apply, in a strong scientific sense, to each and every case of disease of man or mammal.

It admits no dogma, no hypothesis and no statistical probability. It is clear and logical in itself, and can be understood and applied by any normal intelligent person because it follows the causal logic of natural science.

Materialistic, idealistic and metaphysical concepts are out of place here. In truth, we possess no key to understanding metaphysical phenomena. For thousands of years, we thought thunder and lightning were metaphysical forces. Not until recently have we understood them to be electro-physical phenomena. Even though we now understand that the phenomenon of thunder is not due to an act of God, we have not lost our sense of wonder of the unknown.

Physicians have always longed for a body of knowledge that abides by natural and scientific methods and is in accordance with natural scientific laws. However, they have been forced to accept too many hypotheses. and this will be discussed in Chapter 'The Methodology of the NEW MEDICINE'. It became admissible to string a group of hypotheses together to 'prove' the most daring claims. These were only assertions and not real laws, as they exist in natural science.

In what follows, we present five ironclad biological principles that can be reproduced and verified in every comparable case with sound scientific criteria.

There is at present a movement to divide medicine into organic medicine and psychological medicine, or psychotherapy. When a doctor states that there is no organic cause, he is giving the psychotherapist a free hand to treat these 'clean' psychological diseases. Such division is absurd in the eyes of a practitioner of the NEW MEDICINE, because illness cannot be divided and parcelled out. The psyche, brain and organ are three levels of the same organism and the course of events on them is always synchronous!

2.1 The five biological laws of the NEW MEDICINE are:

- The Iron Rule of Cancer
- The law of the two-phased development of every disease to the extent that there is a resolution of the conflict
- The ontogenetic system of tumors and cancer equivalent diseases
- The ontogenetic system of microbes in diseases
- The biological meaning of each Special Program of Nature

2.1.1 The Iron Rule of Cancer

1. Criterion:
Every cancer or cancer-like disease originates with a Dirk Hamer Syndrome ('DHS') which is a

very difficult
highly acute, dramatic and
isolating shock

The experience of shock is simultaneous or virtually simultaneous on three levels:

1. the psyche
2. the brain
3. the organ

2. Criterion:
The content of the conflict caused by the DHS determines, at the very moment of the DHS, the location of the 'Hamerschen Herd' ('HH') in the brain and the corresponding location of the cancer or cancer-equivalent disease in the organ (body).

3. Criterion:
The development of the conflict determines a specific development of the HH in the brain and of the cancer or cancer-equivalent disease in the organ.

2.1.2 The second biological law

Every disease is a two-phased occurrence, as long as there is a resolution of the conflict.

Medical textbooks previously identified a few hundred 'cold' and a few hundred 'warm' diseases.

Patients with 'cold' diseases present with cold skin and cold extremities; they are in protracted stress, lose weight, have difficulty falling asleep and suffer sleep disorders. For examples we have cancer, MS, angina pectoris, neurodermatitis, diabetes and mental and mood disorders.

Other diseases are defined as rheumatic, infectious, allergic, and especially exanthematous.

But we have discovered that this is not correct. These cold and warm diseases were not single illnesses but one of two phases of an illness, the 'cold' being the first and the 'warm' being the second phase. This will be covered more precisely in Chapter 'The Law of the two phases of diseases inasmuch as there is a resolution of conflict'.
Since no single disease was understood correctly, no single case was understood correctly.

2.1.3 The third biological law

The ontogenetic system of tumors and cancer-equivalent diseases.

The interconnections and relationships - covered in detail in Chapter 'The Ontogenetic System of Tumors and Cancer-equivalent diseases and the Ontogenetically supported System of Microbes' - are so fundamentally new that nothing even vaguely equivalent exists in the medical literature today.

The ontogenetic system of tumors and cancer-equivalent diseases includes the following criteria:

1. Criterion:
Conflicts related at the embryonic-layer level also have

- embryonic-layer related cerebral relays
- in cases of conflict, so-called Hamerschenherd ('HH')
- embryonic-layer related organs, which are affected and have
- embryonic-layer related histological formations.

2. Criterion:
Old-brain directed conflicts (brain-stem directed endoderm and cerebellar directed mesoderm) show cell multiplication in the conflict active phase (CA-phase) and destruction or caseation of the tumors by the appropriate microbes, if they exist, in the healing phase (PCL phase).

Cerebral directed conflicts (mesodermal organs directed by loci in the cerebrum and ectodermal organs directed by the cerebral cortex) show cell decrease in the CA-phase (necroses, ulcers) or impairment or interruption of function in the so-called cancer-equivalent diseases.

3. Criterion:
Each so-called illness, in reference to the CA-phase and the PCL phase, is a meaningful biological occurrence to be understood through embryology and behavioural research. This means that the illness is presenting us with the challenge of solving an unusual and unforeseen biological problem.

2.1.4 The fourth biological law

There is a correspondence between embryonic-layer related organ groups - without exception in the PCL phase - and embryonically related groups of microbes. The microbes are not the harbingers of the symptoms, but the optimizers of the healing phase.

All microbes are steered from the brain. The so-called immune system, imagined by us as an army fighting the malignant cancerous cells and microbes in a grand battle, does not exist in this sense. Following instructions from the brain, the pathogenic microbes become benign apathogenic microbes that retreat into a part of the organism where they are no bother and can be recalled and reactivated in the PCL phase on specific organs. Obsessed by our bacteriological, hygienic thinking, we have tried to stamp out these seasonal workers of the organism. As we shall see, by suppressing tuberculosis, we have prevented breast and intestinal tumors in the PCL phase from being caseated by the little souring rods, thereby preventing the consequent tumor destruction. This helped surgery and oncology, but it was biologically and medically wrong.

2.1.5 The fifth biological law

This fifth biological natural law virtually takes us to the 'Original Medicine'; it turns the current nosological (disease) understanding totally on its head. Disease, as it has been defined until now, no longer exists. Our ignorance prevented us from recognizing that all so-called diseases have a special biological meaning.

The fifth biological law is really the quintessence of the four preceding natural laws of the NEW MEDICINE. In hindsight, one could call it the most meaningful of the natural laws. This quintessence not only encapsulates the earlier strongly scientific laws but also opens up a new dimension. It is the soul of the NEW MEDICINE. In one step, it achieves the connection between what can be investigated scientifically and what can be called

transcendental, supernatural, parapsychological or understandable only from a religious point of view. Things that are felt and experienced from a scientific point of view and that cannot be explained and seem puzzling or nonsensical.

With the fifth biological law, we can finally understand our connection to the cosmos around us and in which we are embedded. The Spaniards, who have a feeling for such dimensions of understanding, call the NEW MEDICINE 'la medicina sagrada'. This name came up in Andalucia some time in the spring of 1995.

'La medicina sagrada' opens up a new, cosmic, godly dimension! All of a sudden, our medical thinking and feeling includes every elephant, beetle, bird and dolphin; every microbe, plant and tree. Anything other than this 'cosmic thinking' in the framework of live nature is no longer tenable. While we used to regard Mother Nature as fallible and had the audacity to believe that she constantly made mistakes and caused breakdowns (malignant, senseless, degenerative cancerous growth, etc.) we can now see, as the scales fall from our eyes, that it was our ignorance, arrogance and pride that were and are the only foolishness in our cosmos. We could not understand such a 'sewn up' totality, and so brought upon ourselves this senseless, soulless and brutal medicine.

Full of wonder, we can now understand for the first time that nature is orderly (we already knew that), and every occurrence in nature is meaningful, even in the framework of the whole, and that the events we called 'diseases' are not senseless disturbances to be repaired by sorcerers' apprentices. We can see that nothing is meaningless, malignant or diseased. Why can we not see this interplay of nature in all the inhabited cosmos as something 'godly'? Was it not so before the outbreak of the major religions? From the priests of the god Aesculapius, we learn that the profession of physician was always the profession of a priest.

After the details are set out, biology, human biology and medicine will become clear, transparent, and well understood. As a professor at the Pedagogic Institute in Heidelberg, I taught human biology for many years. I believe that those sessions -'*docendo discimus*' – were responsible for helping me to discover the fifth biological natural law.

3 The Methodology of the NEW MEDICINE

The methodology of the NEW MEDICINE is conceptually easy. Most importantly, it requires a little experience and a healthy understanding of the human psyche, characteristics regarded by medical thinking as unscientific and even nonsensical. Until the present, we have worked predominantly with statistics. We are therefore confronted with the question of whether the person who understands the new methodology and its logic can also learn to be a detective of the psychic level?

The person who comprehends it easily and understands it intuitively is no less qualified than a more intellectually inclined colleague. In fact, the intellectually inclined tend to lack what may be needed to better understand their patients. On the other hand, we know that for the dedicated doctor whose heart and soul is with his patients, nothing is more rewarding than the knowledge and practice of the NEW MEDICINE. Physicians gifted with the right qualities will be able to acquire the necessary all-round knowledge that today's specialists, the so-called 'cream' of the profession, cannot hope to attain.

I do not exaggerate when I state that whoever wants to work with the NEW MEDICINE professionally and is generally experienced in all three levels (of psyche, brain, organ), should first and foremost be a wise and decent person, recognized by the patient as a fellow human being and an extraordinary professional.

Future therapies will entail very little medication but will require the patient's understanding of the root cause of his conflict and disease. Together with his doctor, the patient will find the best resolution to his problem or the best strategy in order to avoid repeating it in the future.

The patient is thus the absolute 'boss' in the treatment and procedure of his illness, and herein is the special aspect of the NEW MEDICINE. The patient will no longer be 'treated', but will 'treat himself'. The relationship between patient and physician will be completely re-thought and re-defined.

Today's highly-qualified and specialized doctor will, in future, have to be a broadly trained, well-educated and humane 'medical detective'. These 'Priests of Aesclepius' must be kind-hearted, wise and possess outstanding general knowledge. I know that this picture does not fit the prevailing one of a 'successful' physician.

Let's go to our subject:

To determine whether he is right or left-handed, the first thing every patient should be asked to do is the clapping test. To establish this, they should spontaneously clap as if they were in the theatre. The hand that is on top striking the other is the leading hand and will determine which cerebellar or cerebral hemisphere is predominant and will suffer a conflict first. In case of uncertainty, this relationship can easily be established and empirically proven with the help of a CT scan. Referring to the patient's brain, we can then conclude whether he is functioning right- or left-handed, independent of the training he received as a child.

The DHS has become the pivot and focal point of the entirety of the NEW MEDICINE. It is such a wonder that we can now accurately calculate and understand the process. We must slip into the patient's skin to try and imagine the entire situation the second the DHS occurred; this happens in the blink of an eye. To do this, we will need to know the patient's personal life history, his experiences and ideas about matters such as religion, society, family, finances, etc. I must emphasize the importance of this methodology in order to avoid the danger of a superficial assessment by a physician who does not take the time or who will not be able to enter the human situation and enter the confessional with his fellow being.

No matter how objective psychological questionnaires seem to be, they do not take into account the peculiarities of the psyche and what occurred in the moment of the DHS.

The scientific chart covers all medicine and enables empirical identification of the correlations between the three levels - psyche, brain and organ - in each individual disease and each phase of a disease or the three levels of the biologically unique programs.

Also to be found on the chart are the types of histological formations that may be expected and the types of microbes that will be present once the biological conflict has been resolved.

Two points determine a line. If we have a third point lying on that line, we can easily crosscheck our evaluation. Staying with this image, we have not three points in one direction, but five, if the histological formation and the corresponding microbes are also included. The development of a disease or of a special biological program for the resolution of a conflict has a number of marking points that may be found:

3.1 The first is the DHS

- the most important point in the entire process. Even the most experienced practitioner in the NEW MEDICINE, which I must modestly admit to being, is not spared the work of following the stages of a conflict. In every single case, I have to work like a brave clinical medical expert and soul-detective, to re-trace the steps of the conflict course and the healing course, all the way back to the DHS. In other words, to the beginning of the entire process.

The DHS embodies not only the *acute dramatic conflict shock* which 'catches us on the wrong foot', but also the *content* of the conflict. The content of the conflict is what determines the location of the 'Hamerschen Herd' ('HH') in the brain and the subsequent location of the cancer growth or necrosis on the organ in the instant of the DHS. However, something else happens during the instant of the DHS: 'tracks' are laid or continuing tracks are laid that remain in the aftermath on which the 'train' runs again and again.

The 'tracks' in the DHS are analogous to the environment, the circumstances that create an association in the second of the DHS. A professor interested in allergies once described this very well with the following formula: *„If you suffer a DHS with a biological conflict and a cow happens to be passing, you will develop an allergy to cows, but if you happen to be biting into an orange, you will develop an allergy to oranges."* In the instant of the DHS, humans and animals are unconsciously 'aware' of their environment. These circumstances later result in so-called allergies.

Two examples will serve to demonstrate this. Hay fever used to be the predominant allergy, although it no longer is today. The reason was simple: the first lovemaking between young people usually took place in haystacks because they were the least expensive and most inconspicuous nuptial beds. DHS's often occurred when these intimate situations were either unexpectedly interrupted or ended unhappily. The partner who experienced the DHS and who suffered the biological conflict might later involuntarily remember the catastrophe in the hay without realizing the connection. The association of the smell of hay is what brings the 'allergy to hay'. The swelling (edema) in the para-nasal sinus, so-called 'hay fever', only occurs in the healing phase. The smell of the hay is connected and associated with the DHS because of the compromising experience.

A second case: During a flight that a couple took from Senegal to Brussels, the husband suffered a heart infarction. They were incapable of doing anything and the wife suffered a death fright conflict from her concern for her husband who could have died at any moment. After landing in Brussels, the husband was rushed to hospital where it was determined that the infarction had not been that severe and he quickly recovered. His wife, however, fell ill

several times with a solitary lung-nodule, after which she would perspire heavily for days or weeks when the tumor would be gone, caseated by the tubercular bacteria.
A solitary cancerous nodule was discovered one day when the patient had again started sweating at night. Her physicians in Brussels were at a loss and requested my assistance. I asked the patient the same questions they had asked her since they were familiar with the NEW MEDICINE: whether her husband was sick again and whether she feared for his life. She said her husband had felt quite well since the heart infarct on the plane. I then asked whether her husband had flown again. She said neither of them had flown since that occasion. She then said she thought her problem was related to planes because ever since that terrible event on the flight from Senegal, she would panic any time her children or grandchildren had to fly; she would feel a death fright for weeks until they were safely back in Brussels. That was exactly what had happened until the solitary lung-nodule was discovered through an aspiration and diagnosed as an adeno carcinoma.
As we can clearly see, the patient suffered a second 'track' during her husband's heart infarct crisis on the plane. This second track is associated with the DHS as a fear of helplessness during the event on the plane. The patient had what every psychologist can understand - a death fright for her husband that re-activated the track by itself as she 'associated' the event anew every time a family member took a plane. It was not really a logical response since her family was young and unlikely to suffer a heart infarct. However, that was not the issue. The point was that the 'plane' became a separate 'track' connected to the 'death fright track' and created a second conflict, a conflict-complex situation, so that every time a member of her family travelled by plane, the patient suffered a recurrence of a solitary lung nodule - the sign of having gone through a death fright for another person. The best way to solve the conflict was for her family to only mention travel by train, even though they really travelled by plane. The patient, a mother and grandmother, would thereafter only hear about their train travel or was only told about a trip after their return.

These examples demonstrate the importance of getting back to the DHS in order to recall the exact situation at the moment of its origin. In philology, this would be called a context: an important passage from a text cannot be omitted, as the text must be understood in its entire context.

Once we have been able to reconstruct the event of the DHS with all its variables from the moment of the event, or regard it as a separate 'track', then the conflict course must be followed from the DHS right up to the present condition. In principle, there are two possibilities:

a) that the patient is still in the conflict active phase (CA-phase), or
b) that the patient is already in the healing phase (PCL-phase)

3.2 The conflict active phase

There are three starting points from which we can begin our diagnosis:

- the psychic level
- he cerebral level, or
- the organic level

A patient usually comes to a medical professional with a variety of symptoms or even a diagnosis on the organic level, in which case I recommend starting from the organic level.
Organic symptoms must be evaluated with great care because there is always the risk that they can be accounted for by old carcinomas that have not been caseated in the healing

phase for lack of tubercular bacteria. A CT scan can easily detect a solitary liver carcinoma if the patient complains of hepatic, ulcerating bile duct liver disorders.

In fact, a start can be made from any of the three levels but should not be confined to one level unless forced by circumstances. I would recommend a brain CT scan in standard layers, since the cerebral level is highly expressive and revealing at the time of the examination. (A scan lasts for four minutes with minimal exposure to radiation). Even here, we must remember that the brain CT is only an instant exposure of a photograph that may show old scar tissue from a previous event. These scars can and do indicate the event of the impact of the DHS but only then, when the last visible type of image of the biological conflict had lasted continuously throughout the conflict active phase.

The psyche is the most interesting and informative level, especially with respect to the 'tracks' that are simultaneously established at the time of the DHS. Only the patient can recall how the conflict affected him in the moment of the DHS.

I once saw a patient with a right-sided ductal mammary carcinoma that had been amputated. From the conflict course and from a rational evaluation of the symptoms, it seemed clear that the DHS had occurred because of an abortion. At first, this connection was neither logical nor familiar because a right-handed mother usually feels a separation conflict from her child (embryo) as the result of an abortion and would succumb to a left mammary carcinoma. The patient assured me right away that it was not the child she was concerned about but her boyfriend, who had disappeared shortly after the abortion. When the boyfriend reappeared three months later and moved back in, she discovered a large swelling in her right breast (as a result of being separated from him).

It is beyond the scope of this summary to present more cases and constellations. I have saved them for another book entitled '*Differential Diagnosis in the NEW MEDICINE*'.

3.3 The conflict resolution (conflictolysis) (CL)

The conflictolysis is a very specific point that must not be overlooked. The turning point of the vegetative innervation from a lasting sympathicotony to a lasting vagotony is a very powerful seizure that is psychic, vegetative-cerebral or organic. At an organic level, fever or influenza is often diagnosed.

Every disease has its very clearly defined PCL symptoms that begin with the CL. I do not believe it is difficult to find the CL in a one-cycle disease. It gets difficult when it comes to a 'hanging conflict' where there has not yet been a CL. It is also difficult where there are constant relapses and constant conflict resolutions. An example of 'hanging healing' is Morbus Parkinson's disease where the trembling, mostly of hands, indicates a healing phase, and the patient suffers a conflict relapse at night in a dream state.

Why is it important to find out the time of the CL so precisely, especially in a one-cycle course where the CA-phase and the PCL-phase are uninterrupted? It is because the accurate determination of time can mean life or death for the patient. By establishing the time of the DHS to the time of the CL to the present condition, an estimate can be made as to what stage the patient is in at that moment: Is the patient still facing an epileptoid crisis (EC)? Has the epileptoid crisis already passed? What actual danger exists? Of importance with leukaemia is the calculation in which the preceding anaemia continues to exist with the CL, whereby through the enlargement of the vessels, the calculation can still increase significantly to a 'half-pseudo-anaemia'. Patients should be watched very carefully during the two weeks after the CL. They must remain calm and should not take any risks or be given unnecessary blood transfusions. If a transfusion is needed, it should be administered at night (especially with children) in order to avoid a possible 'bleeding and injury conflict'

for the patient. While in a panic, our brain cannot tell the difference between losing blood and a blood transfusion or having 'blood cancer', a term still in use today.

3.4 The patient in the healing phase

In this phase the patient's outer symptoms are warm hands, weakness, fatigue, good appetite and finally possible fever and a lasting vagotonia.

As soon as the doctor determines that the patient is in the healing phase, he must move very fast to establish what stage of the healing phase the patient is in. He must also find the exact moment of the DHS and determine the duration of his conflict in order to answer this question:

Is the patient in a pre- or post-epileptoid crisis? Does the epileptoid crisis in this particular disease have a high mortality rate?

If we are dealing with an old brain directed disease, we have to question whether the tuberculosis has started or whether the patient should be helped in developing a tubercular infection.

The healing progression may already be well advanced and without tuberculosis bacteria so that surgery may be appropriate, in the case of an intestinal cancer, in order to avoid an intestinal obstruction. However, only the minimum should be extirpated in such an operation, and no more than 15 cm of the large intestine or, if it is technically possible, cut back the tumor without risk of bleeding. The earlier maxim to cut deep into the healthy tissue to avoid metastasis is unfounded and absurd.

Other differential-diagnostic considerations have to be adopted when dealing with the growth of a real thyroid adenoma caused by a conflict of 'not having been fast enough to catch the morsel'. If no tuberculosis is present in the healing phase, or if tuberculosis would not be helpful for the remainder of the healing phase, then an operation is needed to lower the thyroxin rate, something Mother Nature would have regulated after the breakdown of the adenoma.

The healing phases have been misunderstood as 'infectious diseases'. Categorizing them correctly does not mean that things will be easier in the future from a therapeutic point of view. Knowing the exact time of the DHS and the duration of the conflict active phase will help us to prepare for what is to come. The better we can supervise the events, the calmer the patient will be.

Matters obviously become more complicated if there are several biological conflicts running at the same time so it is very important to know whether the phases are developing in the same direction or in opposite directions. If a patient is suffering a PCL phase of a biological conflict and a CA-phase of a second biological conflict simultaneously, then the cautious use of cortisone should be considered. It should be avoided, however, if possible. Very important in this connection is the brain edema of the HH in the PCL phase that, unfortunately, is misdiagnosed as a 'brain tumor' and unnecessarily operated on (see Chapter 'The Hamerschen Herde').

3.4.1 The epileptic/epileptoid crisis (EC)

As harmless as the PCL phase may be in several diseases, death is a possibility if care is not taken. The epileptoid crisis often presents a real challenge, even for experienced clinicians. The EC is the hour of truth for a number of cortical cerebral-directed organ diseases such as cardiac infarction, left cardiac infarction and right cardiac infarction with pulmonary embolism, lyses of pneumonia, lysis of laryngeal carcinoma, branchial/pharyngeal cysts, diabetes, hypoglycaemia, sensory paralysis and sensory-

periosteal paralysis. More details for each of these diseases can be obtained from the scientific chart.

These distinctive points can be reproduced in every patient. The more precise and scientific this becomes, the better the chances for our patients. If we are able to tell them (other than a few extreme cases) that they will survive, they will mobilize a phenomenal strength and will work enthusiastically on their recovery as 'manager of developments'.

4 Validation and Proof in the NEW MEDICINE

4.1 How does one prove any case for repeatability according to the biological laws of the NEW MEDICINE?

During the last thirteen years, a large number of repeatability tests have been performed, most of them in public, and none of them different from what I recommended thirteen years ago to a number of professors at the University of Tübingen in Germany. I had even agreed to the tests being carried out behind closed doors, if that was what they wanted.

Scientific rules of reproducibility should always be employed to test whether any number of identical cases can be explained and traced by the laws of the NEW MEDICINE.

4.2 What is scientific reproducibility?

In the hard physical sciences (physics and chemistry), the strength of proof of a law depends exclusively on the public reproducibility of the identical experiment. *Mutatis mutandis*, it is also true for the biological laws of the NEW MEDICINE for the identical type of disease of each and every patient.

In the physical sciences, the same material that was used for test A is not used for test B, but an equivalent material is used. In chemistry, the same water is not used from a previous test, but equivalent water (H2O). In the same way, one cannot use patient 'B' for the same demonstration as patient 'A', but only an identical, circumstantially equivalent case.

Should the need arise to reproduce the patients' cases according to the five biological laws of the NEW MEDICINE, the matter in principle is very simple.

There are three levels that must run synchronously, as well as two disease phases (provided the conflict can be solved). A phase of normality comes prior to the sympathicotonic phase and at the end of the vagotonic healing phase there is a normotonia that can be seen from the remaining scars on the psychic, cerebral and organic levels and can easily be differentiated from the pre-existing 'intact' normal phase.

We thus have not only the four phase-segments on each of the three levels, but additionally, three well-marked points (DHS, CL and EC) on each of the three levels, giving 21 criteria which, according to the five biological laws, can also be tested separately.

Since the five biological laws together contain a minimum of six criteria - the histological, the cerebral topographic, the organ topographic, the conflict colouring and the microbial - we can end up with 126 testable and reproducible facts for every single case, if all three levels can be very closely examined.

That only one single case would accidentally exhibit these 126 reproduced facts is an astronomical improbability, since it is only the next-best case out of millions of possible cases.

However, if a patient has only two diseases occurring in part in parallel or partially in succession, then we can add the testable facts and obtain 252; the likelihood on the other hand escalates exponentially and to astronomically high values.

The most important criterion to be included in the calculation is that the localization of the HH in the brain is pre-determined. It means that this relay, one of several hundred possible relays, is already established. In the case of a disease, this relay is the HH and must have the exact appearance belonging to the corresponding phase. The probability for only a single case reaches already astronomic proportions. Consider that at each of my reviews, patients had several cancers or paralysis, diabetes or the like, and for each single disease, all the criteria had to be fulfilled...!

5 The Iron Rule of Cancer

The discovery of the NEW MEDICINE began with the death of my son Dirk who was mortally wounded in August 1978 by the Italian crown prince on the Mediterranean island of Cavallo. He died in my arms under appalling circumstances at the University of Heidelberg on December 7, 1978.

I then fell ill with a testicular carcinoma, more precisely, a teratoma of the right testicle. I prevailed against the advice of the professors at Tübingen who thought that the swollen testicle should be operated. Since I had never really been seriously sick, I had a vague suspicion that the death of my son had led to some type of physical manifestation. After my recovery, I decided to investigate this idea as soon as I had the opportunity.

The opportunity presented itself when I became the head doctor for a cancer clinic.

Discovered in the summer of 1981, the IRON RULE OF CANCER seemed to have validity only for certain types of gynaecological cancers. However, it was soon obvious that it applied to all sorts of other cancers as well. I finally determined that all diseases were either cancers or cancer equivalents - something similar to cancer. For that reason, it was logical that the IRON RULE OF CANCER would apply to all diseases known to medicine so, instead of calling the law 'THE IRON RULE OF ALL OF MEDICINE', the original name stuck.

5.1 The 1. Criterion of the Iron Rule of Cancer

... describes the conditions for the generation of a biological conflict and is quite differentiated from the so-called psychological or psychic conflicts, better referred to on the whole as psychological conflicts. These are chronic, long-lasting conflicts, specifically problems or equivalents for which one has time to prepare or which one can anticipate. The time required to prepare need not be long, sometimes just a few seconds. As humans, we can usually master psychological conflicts and problems of a nature that are known to us or for which we have some brief time to prepare.

Directly opposed to this psychological conflict is the biological conflict for man and animal (mammals), and presumably the course of events is the same or analogous for all animals and even plants. The biological conflict is a serious, highly acute, dramatic and isolating shock that catches us totally unprepared.

The IRON RULE OF CANCER

The IRON RULE OF CANCER is an empirically discovered natural biological law that has been correct without exception in the 10,000 cases I have investigated.

It is an over-determined system of three correlated functions, where I can establish the other two from one known one every time.

The IRON RULE OF CANCER states:

1. Criterion:

Every cancer or cancer-like disease originates with a DHS, which is a

most difficult
highly acute, dramatic and
isolating

life-experience-shock, simultaneous or virtually simultaneous on three levels:

1. the psyche
2. the brain
3. the organ

2. Criterion:

At the moment of the DHS, the conflict contents determine the location of the HAMERschenherd (HH) in the brain and the location of the cancer or cancer-equivalent disease in the organ.

3. Criterion:

The development of the conflict determines a definite development of the HH in the brain and a very definite development of the cancer or cancer-equivalent disease in the organ.

I have known several patients who lost three or even four immediate relatives who were very close to them. Loss was especially significant with one of these patients. Her uncle, the last of the relatives to die, owned a beautiful old chest that had allegedly been promised to the patient. Her uncle's will, however, bequeathed it to the patient's sister. This caught my patient totally unaware, 'on the wrong foot'; she had been counting on the piece and had already prepared a place of honour for it in the living room. Because she basically already owned the thing in her mind and now had to give it up, she suffered uncontrollable anger and developed a pancreatic carcinoma. On a 'psychological' level, the death ('loss') of each of the four relatives should have been far more meaningful, but that was not the case. However sad their passing, she knew in advance that nothing could be done. They were duly mourned. This was a psychic or psychological loss conflict, not a biological one. Not getting the chest, on the other hand, caught the patient totally on 'the wrong foot' and brought about a biological conflict resulting in pancreatic cancer.

Psychologists always look for psychologically relevant, overt, latent conflicts that have developed over a long time, usually carried over from infancy or youth. They look for conflicts between human instinctual structures and the alleged I-authority system or, typically, for loss conflicts with respect to relatives. These are really never to be found!

Psychologists have not considered the moment of 'the-unexpected-impact'. The statistics for the psychosomatic are therefore senseless or absurd, because they have not learned to think 'biologically'. In Chapter 'Statistics as presently applied in Medicine', I go into greater detail in my criticism of this subject.

5.1.1 Definition of the biological conflicts

1. The DHS develops through a life-shock-conflict of a serious psychic nature that is highly dramatic, acute and isolating and that catches us unprepared and on the wrong foot.
2. The DHS, with the consequent incipient biological conflict, is not just a negative disturbance of a life-routine, but a shock that triggers the organism to turn on the specific emergency or special program available for just such an occasion. It is only after a DHS and the biological conflict occurs that the hardware in the brain provides the organism with the opportunity to make up for the momentarily missing examination of qualifications.
3. Allergy, Tracks: If the individual has already experienced a DHS for the same or a similar event, then the organism is more attentive to that type of biological conflict. We could, in a negative way, say that the patient always falls into old traps. Positively, we could say: the patient pays hellish attention and reacts immediately with a special program.
4. The biological conflict is used by Mother Nature to direct and control the social co-existence of families, herds, packs, etc. This is fundamental in cerebral-cortex cases of biological conflicts. Where necessary, in certain instances, the special programs remain active for a lifetime.
5. When a real solution to a biological problem is unlikely and when even the active hanging conflict is not sufficient, nature freezes the individual in the momentary development stage through the cerebral-cortical schizophrenic constellation.

A very important qualification of the IRON RULE OF CANCER is that all events - the beginning of the biological conflict as well as the resolution of the conflict or the epileptic/epileptoid crisis - should take place synchronously on the three levels, psyche - brain - organ.

In the NEW MEDICINE it would be absurd to ask whether or not a psychological event could resolve a bodily event. In the NEW MEDICINE a psychological event is parallel in meaning, equivalent and synchronous with a bodily/organic event.

This synchronicity is not a mere hypothesis or a philosophical postulate, but can be solidly proven on each of the three levels and in each individual portion or phase of the development. We can even provide excellent proof at the psychic level with the help of vegetative parameters.

With respect to this first law of the IRON RULE OF CANCER, the DHS (DIRK-HAMER-SYNDROME) is of central importance.

5.2 The 2. Criterion of the Iron Rule of Cancer

In the moment of the DHS, everything is already programmed or pre-programmed, corresponding to the conflict contents. In the moment of the DHS there is, as we can easily prove today with CT scans, a switching-on of an HH in a definite, previously determined area of the brain.

In the same moment, the predictable, empirically observed changes on the organ begin to appear: cell multiplication or cell decrease or functional disturbances (in the so-called cancer equivalent diseases).

I say 'switched-on' because, as I will show in a later chapter, the DHS is the turning-on procedure for a special program that allows the organism to deal with an unforeseen situation.

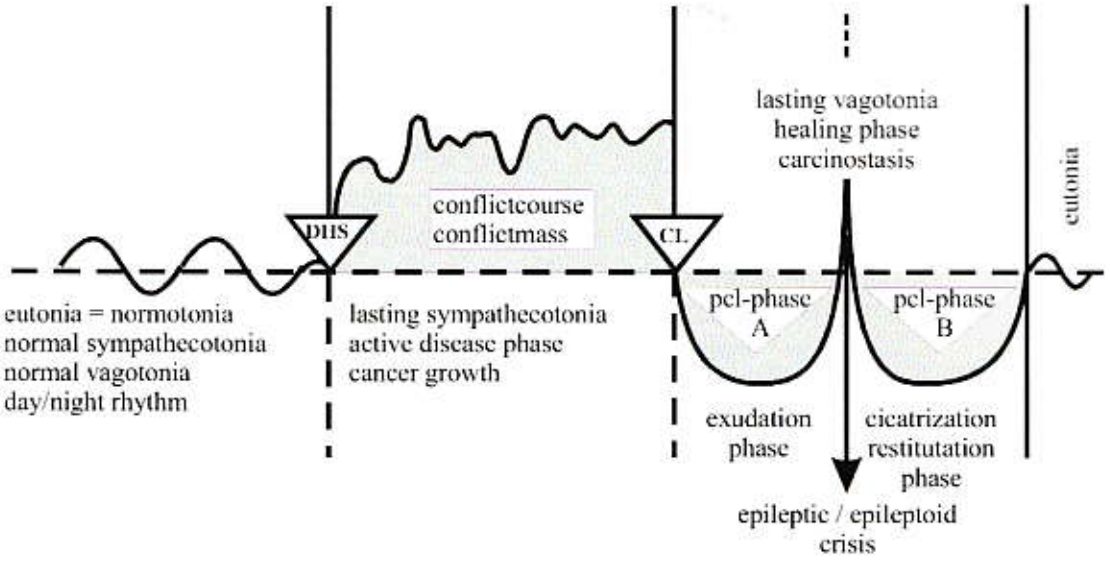
Strictly speaking, diseases do not exist in the sense we have been taught them in universities. We interpret diseases as Mother Nature's mistakes, or as the 'immune system' having weakened. But Mother Nature does not make any mistakes; everything is intentional and may contain meaning for the purpose of the larger group, even though the individual may experience negative secondary impacts.

5.3 The 3. Criterion of the Iron Rule of Cancer

... states that the development of all so-called diseases is synchronous on the three levels. At the same time, very precise criteria establish what the typical conflict-active symptoms and healing-phase symptoms are on the psyche, brain and organ levels. Added to this are the symptoms typical on all three levels during the epileptic or epileptoid crisis, which are a little different for all diseases, but also typical of each disease given the brain and organic symptoms (for example, epileptoid of stomach ulcers, epileptoid of bile-duct ulcer, so-called lysis crises in cases of pneumonia = bronchial-ulcers-epileptoid, heart infarction = coronary-ulcers-epileptoid, etc.) and just as typical for the psychic and vegetative symptoms.

Armed with this knowledge of the natural laws and the typical symptoms of the development on the three levels, we can, for the first time, work causally and meaningfully in a virtually reproducible manner.

6 The Law of the two phases of diseases inasmuch as there is a resolution of conflict



The above diagram shows normal day/night rhythm on the left.

The conflict-active (CA) stress-phase or lasting-day phase, also known as lasting sympathicotonia, comes after the DHS.

The resolution of the conflict is followed by the conflictolysis (CL), the healing-phase or lasting-night phase, also known as lasting vagotonia; this is interrupted by the epileptic or epileptoid crisis which signals the turning point of the healing-phase.

From here, the organism strives to return to normality.

At the conclusion of the healing-phase, normal day/night rhythm is re-established.

Every disease (in all of medicine) has two phases; an initial conflict-active, cold, sympathicotonic phase (CA-phase) that starts with the DHS, and a second conflict-resolution or healing-phase, warm or vagotonic phase, if there has been a resolution of the conflict. This is also known as the post conflictolytic phase or PCL-phase, for short.

Where there is conflict resolution, all diseases have both a CA-phase and a PCL-phase. As long as it is not interrupted by a conflict relapse, each PCL-phase has an epileptic or epileptoid crisis at the deepest point of the vagotonia.

This law of two-phases stands current medical knowledge on its head.

After careful examination, we find that in about half of the few hundred diseases known, patients present with cold hands and a cold periphery. In the other half, the warm or hot diseases, patients present with warm or hot hands and, in most cases, with fever. There are actually only 500 tandems: at the beginning - after the DHS - a cold, conflict-active, sympathicotonic phase, followed by a warm, conflict-resolved, vagotonic healing-phase. This scheme of the two phases is a biological natural law.

All diseases follow this course – as long as there is conflict resolution. Looking back, we can now see that standard medical practice has not recognized one single disease correctly. With the cold diseases, the subsequent healing-phase was either overlooked or (mis)diagnosed as a separate disease ('flu, for example). With the 'warm diseases', which represent the second phase, they were usually (mis)diagnosed as a totally separate disease.

Both phases have their HH in the same place on the brain, although they manifest differently: as a target configuration in the conflict-active phase, and as a swollen, edematous configuration in the conflict-solved phase. The edema of the inner ring is called

the 'intra-focal edema', while the edema around the outer ring is called 'perifocal'. This is not precise terminology, however, for something that is very clear in itself. From the start of the healing-phase it is usually possible to dye the HH with a contrasting substance. At the end of the healing-phase, we find varying amounts of (neuro)glia in the HH, stored there as a sign of the restoration of the nerve cells and synapses. These basically innocent (neuro)glioma are usually identified as brain tumors or brain metastases, even though they are actually healing or healed HH's.

6.1 The First Phase

A.	psychic level	=	Conflict activity • compulsive thinking about the conflict • stress innervation to deal with the conflict • lasting day-rhythm
	vegetative level	=	Sympathicotonia • lack of appetite • loss of weight • vascular changes • cold hands and feet • cold skin • sleeplessness • waking up shortly after falling asleep • elevated blood pressure
B.	cerebral level	=	target configuration of the HH on the brain in the location corresponding to the appropriate organ
C.	organic level	=	a) organs directed by the old brain • cell-multiplication as meaningful occurrence for resolution of the conflict b) organs directed by the cerebrum: • necroses or ulcerations, depending on organ, cell loss or disappearance meaningful occurrence to resolve the conflict for the individual or meaningful occurrence as a virtual suicide program for preservation of the species (food for the lions).

6.2 The Second Phase:

A.	psychic level	=	Conflict-resolved phase (PCL-phase) • great relief • lasting night-rhythm
	vegetative level	=	• considerable fatigue • vagotonia • good appetite • sense of well-being • fever • sleep disturbance until 3 a.m. (sunrise, biological beginning of the day; for the 'prey-animal' less chance of being surprised by predators during the daylight hours while asleep) • distal vascular: warm hands, warm feet, warm skin, low

			blood pressure.
B.	cerebral level	=	The target-rings of the HH become edematous in the PCL-phase, and are often submerged in the edema (intra-focal and perifocal edema). From the start of the healing-phase the HH can be dyed with contrasting substance but it is usually misdiagnosed as a brain tumor. Dyeing with a contrast substance is possible because there is a significantly increased substance transfer in the vicinity of the HH and storage of neuroglia, brain-binding tissue to repair the altered relays. The price to pay is that it becomes more rigid, stiff and less elastic. If there is an identical development later in the same relay, it can lead to a rupture (cyst) of the brain tissue. At the end of the PCL-phase, after the 'pee-pee phase' (diuresis-phase), the edema re-absorbs spontaneously, as a sign of the healed HH.
C.	organic level	=	a) Organs directed by the old brain: • destruction of the cell multiplication (only of the tumor's cells) in the PCL-phase by fungus or fungus-bacteria (TBC) until the status quo ante. If the microbes are not available (because of well-meaning but misplaced hygiene), then the tumor stays in place but does not undergo mitosis after the CL; the biological cell destruction does not take place. b) Organs controlled by the cerebrum: • reconstruction of the missing cells due to the previous destructive process, i.e. replenishing of the necrotic or ulcerated tissues, depending on availability, with help from bacteria (cerebral or medullary layer directed organs) or viruses (cerebral cortex directed organs).

Without these biological laws, we were unable to classify medicine or to understand a single disease correctly. It has been impossible to understand cancer as we have considered it incurable. Our approach was to remove the organic cause of the cancer - a grave mistake from a biological point of view. For the same reason, we did not understand infectious diseases and considered microbes to be aggressors trying to defeat us, rather than helpers that heal us.

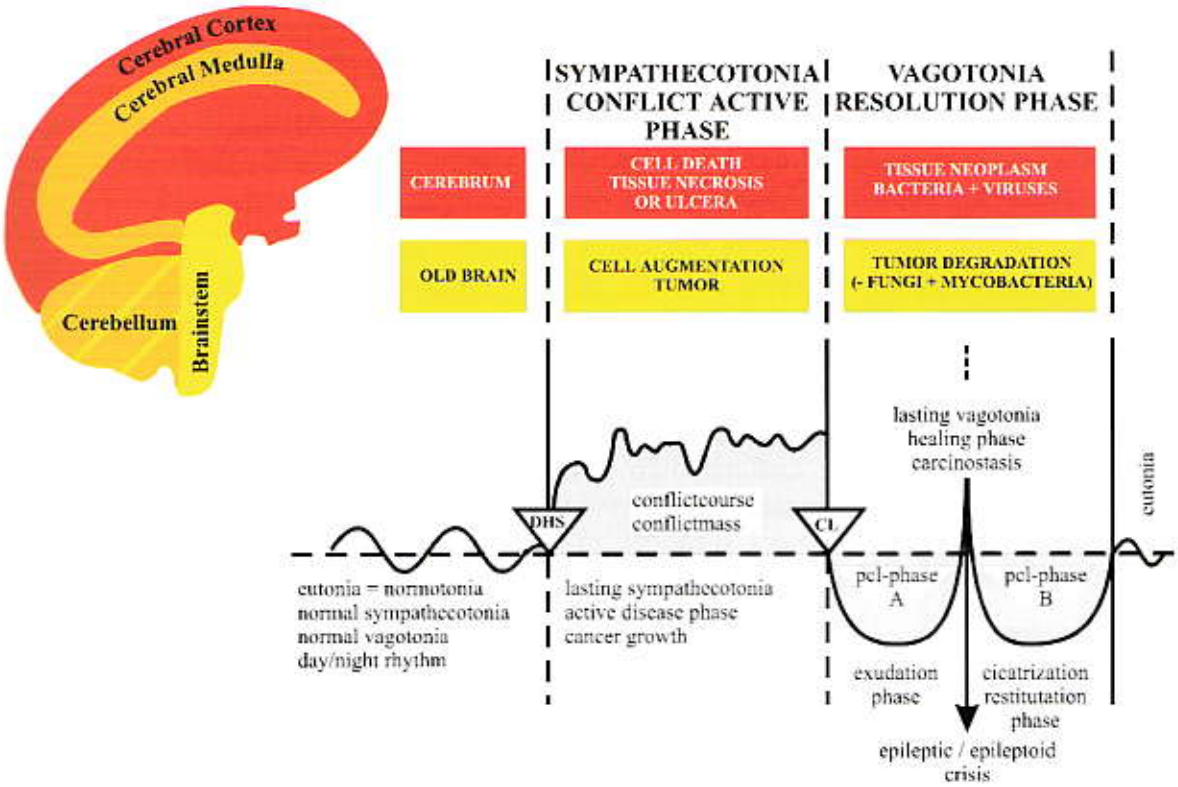
The exact opposite was the case. Patients who died did so in spite of the microbes during a brain coma or an epileptoid crisis. This does not mean there is no danger during the healing-phase, as we shall see later. In fact, the healing-phase in many diseases is considerably more dangerous than the conflict-active phase.

Since we were unaware of these biological natural laws, it was impossible to identify or understand disease and therefore impossible to treat patients, since the healing phase was thought to be a disease in itself.

7 The Ontogenetic System of Tumors and Cancer-equivalent diseases and the Ontogenetically supported System of Microbes

(Third and fourth natural biological laws)

THE ONTOGENETIC SYSTEM OF TUMORS MEANINGFUL SPECIAL BIOLOGICAL PROGRAMS OF NATURE



We see two separate groups in the figure above (see also the large folding chart): The yellow or old-brain group and the red or cerebrum group.
This division of the brain corresponds to the natural law of embryology.
In the conflict-active phase, the yellow group creates tumors from cell multiplication.
In the conflict active phase, the red group creates necroses and ulcers from cell destruction.
In the healing-phase the opposite applies. The old-brain yellow group destroys tumors through microbes whereas the cerebrum, red group repairs the damage of cell-loss of necroses and ulcers through swelling and the formation of cysts.

The IRON RULE OF CANCER and the law of the two phases of all diseases upon resolution of the conflict were prerequisites to the discovery of the ontogenetic system of tumors and cancer-equivalent diseases. In a logical, understandable form and from an evolutionary point of view, it shows the inner connections between conflicts, the corresponding brain area and the related organ.

With it we can make sense of and provide an order for the entire histopathology of organs. The relays for similar conflicts and for histologically equal organs are located very close to each other in the brain.

However, this ontogenetic system of tumors and cancer-equivalent diseases also shows that we never understood cancer, because without this knowledge it was incorrectly

categorized: the old-brain controlled organ tumors are initiated in the conflict-active phase and often wrongly catalogued with the cerebrum directed 'tumors', which only show cell-multiplication in the healing-phase and are erroneously classified as tumors.

If anyone ever claimed that a system in cancer had been discovered, it would have been wrong, as we see in the so-called tumor markers, which, in hindsight, are demonstrated to be absurd, and exactly the opposite of what they really mean. Since we did not know the difference between old-brain directed organ-changes and cerebrum directed organ-changes, it was impossible to find common characteristics, and if we had, they would have been wrong.

The ontogenetic system of tumors is encompassing and logical in itself. It follows naturally from the IRON RULE OF CANCER and the discovery of the HH's in the brain.

This total ontogenetic system of medicine, in particular of tumors, is as significant for medicine as the periodic table of elements is for the natural sciences, in that it describes the interactions in the entirety of medicine.

The ontogenetic system of tumors and cancer-equivalent diseases states:

1. The three embryonic layers describe specific types of histological tissue which are equal or at least similar to each other. Unfortunately, the mesoderm is split into an old or cerebellar mesoderm and a new or cerebral mesoderm. The cerebellar mesoderm behaves in a similar way to the brain-stem endoderm, whereas the cerebral mesoderm is similar to the cerebral ectoderm.
2. In the case of a DHS leading to an HH, the organs corresponding to the HH react appropriately for that particular embryonic layer.
3. The healing-phase is very different in each of the three embryonic layers after conflictolysis (conflict resolution).

Inner germ layer:
Cessation of cancer-growth, encapsulation or destruction by fungi or myco-bacteria, e.g. through tubercular-bacteria.

Middle germ layer:

a) Cerebellar-mesoderm:
   Growth stops, encapsulation or destruction by bacteria as with the inner layer, e.g. mammary-Ca by bacteria or myco-bacteria.
b) Cerebral-medulla-mesoderm:
   Regeneration with swelling and excessive growth as in a sarcoma or osteo-sarcoma in the case of bones with multiple callus. The excessive growth is totally harmless and ends spontaneously with the completion of the healing-phase. Bacteria are helpful in re-building.

Outer germ layer:
Tendency to filling up of the ulcer-necroses with reconstruction or scar reconstruction with the help from viruses.

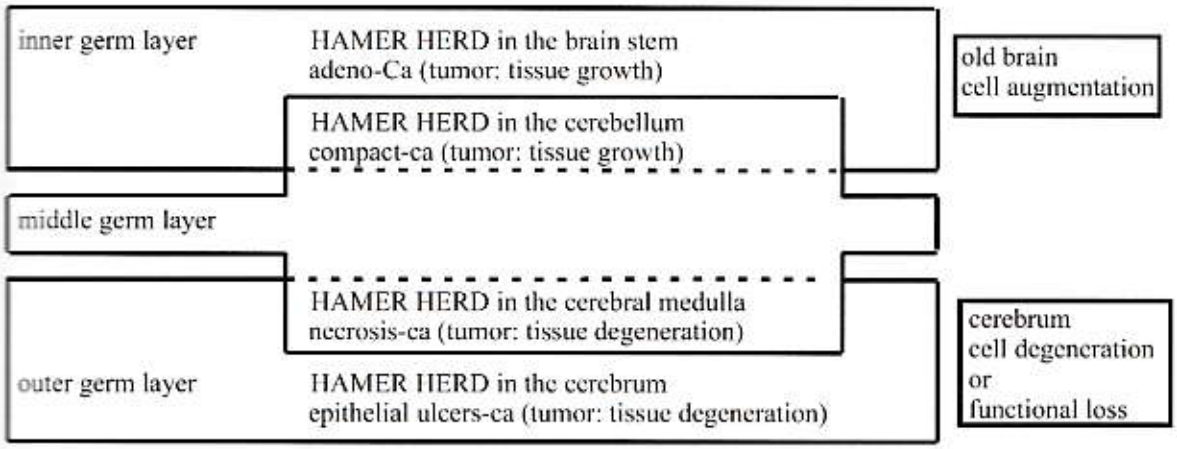
For the first time, the IRON RULE OF CANCER presents us with a clear system with which to understand the nature of tumors. Many questions remain open, but I think I have now succeeded in finding a comprehensive system, not only for tumors, but for all of medicine. The disturbance that a biological conflict brings to our behaviour is a special event; it is a program alteration in a location of the brain - the HH - that had functioned normally and with amazing precision millions of times before. What is breathtaking about the program-switch is that even though the whole organism is called into play by the DHS, that program alteration, which I had previously considered to be mistaken control signals,

is actually a 'last resort' system in the battle for survival, using all available energy. This programming switch is a meaningful event.

7.1 Classification of the growths

For years I assumed that there was no system in the morphological and histological characteristics of the various growths, swellings, tumors, carcinomas, sarcomas, chorio-carcinomas or neurogliomas - what traditional medicine regards as metastases. I believe I have found a classification that, with minor alterations, will be used for decades to come. It is a classification based on evolution or embryology.

From an evolutionary point of view, when these swellings and growths are sorted by criteria specifically dictated by the various germ layers of their origin, things all of a sudden become organized. As a result of the millions of years in the evolution of man and animal, it may be the brain that is really the computer of the organism, so that logically, the evolutionarily interdependent bodily organs also have to coexist in the computer brain.



Embryology generally divides evolution into three layers, the endoderm, or inner germ layer, the mesoderm or middle germ layer and the ectoderm or outer germ layer. Most of our organs originate from only one of these layers. For example, the stomach-intestine-canal (not including the rectum, the upper two-thirds of the oesophagus, the small curvature of the stomach, ducts of the liver, ducts of the gallbladder, pancreatic ducts and the islets of the pancreas) originates in the endoderm, or inner germ layer.

However, the intestine is supplied by blood vessels belonging to the middle germ layer. The intestine, therefore, also has a mesodermal component, and since a network of nerves also supplies it - the so-called autonomic nervous system - it also includes ectodermal tissue.

When we speak of an organ that is of endodermal origin, we do not mean the mesodermal vascular network, or the ectodermal nervous web, which all organs possess.

There are also organs that are functionally made up of different parts emanating from different germ layers, notably, the head, the pulmonary area with the heart area, stomach, liver, pancreas, duodenum, and the vesico-vagino-anal area including the renal pelvis. Some of these functionally merged organs of later development, today regarded as organs, often have their relay centres in widely separated areas of the brain.

For example: the uterus is really made up of two separate organs, the cervix and a womb with fallopian tubes. These different organs have apparently grown together to become one organ, the 'uterus', but the mucous membrane of the two organs originates in different embryonal germ-layers and have their relay-centres in very different areas of the

brain: the cervix and the cervical collum in the peri-insular area of the cerebrum is on the left and the womb-mucous membrane is in the pons of the brain-stem.

Correspondingly, the histological formations are also totally different from each other: the cervix has squamous epithelium; the womb has adeno-epithelium or cylindrical epithelium in the pons of the brain stem. Added to this is the mesodermal musculature of the womb, with its relay in the midbrain/brain-stem. This is why it was so difficult to establish relationships and connections.

In contrast, there are organs that lie far apart from each other in the body - for example, the rectum, the vagina, the coronary veins and laryngeal squamous epithelium peri-insular - which are found in the left cerebrum - and the intra-bronchial squamous epithelium, the intimal coronary epithelium and the bladder epithelium - which are located very close together on the right peri-insular area of the cerebrum.

If I had not continued to compare brain areas, 'homunculus' (see drawings), histological formations, embryological research results, textbooks and my own brain-CT's with all the patient histories, I would still be dwelling on this because there are mistakes in almost all the embryology texts since nobody suspected an inter-relation.

I know that the mucous membrane areas endowed with squamous epithelium all belong together, have an ectodermal origin and correspond together in the brain. As well, clearly differentiable organs - such as the mucous membrane of the mouth, of the bronchia, of the larynx and of the pharyngeal arch, the intima of the coronary arteries and of the coronary veins, the mucous membrane of the rectum and of the cervix, all belong together. They all have a right and left peri-insular relay centre and their conflict contents are sexual, territorial or territory marking.

7.1.1 Cerebellar mesoderm and cerebral ectoderm

I have always had difficulty with taking embryology as my starting point. Embryologists have not concerned themselves with questions that did not seem especially important to them. Skin is of ectodermal origin, but only the epidermis. Underskin (corium) has a mesodermal origin. There are these fine distinctions in the so-called skin layers. In fact, there is an inner layer of skin (corium) of mesodermal origin that contains glands (sweat-glands, sebaceous-glands) and melanophores. On top is the most outer epidermis of the squamous epithelium that is of ectodermal origin. The surface contains sensitive tactile nerve-endings and below the surface is a layer of melanophores. The subtle difference is that one cell is innervated from the cerebellum while the other is innervated from the cerebrum. Again, this determines their function, their histological construction and their various tumor reactions or tumor formations.

7.1.1.1 The cerebellar mesoderm

The cerebellum was forming around the time our evolutionary forefathers were abandoning the sea for the land. It was the time when a skin was required that would provide stability and protection from the excessive radiation of the sun, and prevention from drying out. I will call this organ the mesodermal cerebral-skin.

This cerebral-skin was not burdened with great mechanical complexity. The creature moved by crawling in a worm-like fashion. The skin had unspecific 'protopathic sensitivity' which is the ability to sense extreme pressure and temperature. It also had the capacity to adapt and react when environmental conditions changed drastically. This skin stored the melanophores that, with their pigmentation, gave protection from the ultra violet radiation of the sun. Aside from this, it generated a thin film of humidity through the

sudorific glands and could protect itself from burns through the cold of evaporation. The creature was thus fairly well protected against the dangers threatening his vital sphere.

Mammalian behaviour developed after completion of this cerebellar-skin, whose relays can be found in the medial posterior and lateral cerebellum (conflicts of this area include feelings of being soiled and injury to one's integrity). The nipple was logically also housed in the skin. The milk glands are consequently an invagination of this cerebellar-skin out of which the suckling can take its milk. All this lies in a very orderly fashion side by side in the cerebellum.

The original glandular epithelium of the milk ducts obviously no longer belongs to the type of gland associated with the intestinal tract, yet it is morphologically more related to it than to the squamous epithelium of the outer layer of the skin. Both are very different - because their origin in the brain is very different! The best classification for the glandular epithelium of the milk ducts and the sudorific and sebaceous glands would therefore be that of 'cerebellar-glandular tissues'.

The 'inner' skin of the body also belongs to the cerebellar-skin: in the stomach cavity, the peritoneum, in the chest, the pleura and in the mediastinal area, the pericardium. Here again we differentiate the parietal peritoneum and the visceral peritoneum, as well as the parietal pleura and the visceral pleura and the parietal and visceral pericardium. Their cancers are therefore called mesotheliomas.

A cancer in the corium skin directed by the cerebellum obviously develops as a growth! This cerebellum skin is responsible for edema and discharges in the healing phase such as peritoneal liquid or ascites, pleural liquid or pleurorrhoea and the feared pericardium liquid with the tamponade of the pericardium! In principle, this is very good, but it is a complication I greatly fear because it accompanies the unfolding of the healing phase.

7.1.1.2 The cerebral ectoderm

In time, the cerebellar-skin proved insufficient. Mother Nature therefore undertook a giant new project for the new brain: a second skin, a cerebral skin, to cover the creature.

This cerebral skin, of ectodermal origin as opposed to the mesodermal cerebellar skin, was a resistant squamous epithelium skin. This squamous epithelium skin, assigned to the cerebrum, wandered along the segments and covered the cerebellar skin completely. It brought with it the surface-sensitivity of the cerebrum (sensitivity centre of the post-centralis gyrus) and placed the highest organized organisms in a position to obtain all the necessary information needed to adapt to the requirements of the quick and dangerous fight for survival.

The formation of the squamous epithelium is the typical morphological sign of the cerebral skin or cerebral epithelium. This skin did not stop at the edges of the cerebellar skin but covered the endodermal cylinder epithelium in the bladder, the endoderm in the renal pelvis, the endodermal epithelium in the mouth and upper oesophagus, the small curvature of the stomach and gall bladder, the pancreatic ducts and the adenoidal (intra-ductal) epithelium of the milk-ducts. Because of this, we find the typical cerebral squamous epithelium in the outer skin, in the mucous membrane of the mouth and nose respiratory area, the squamous epithelium of the larynx, the bronchia, the oesophagus, the pylorus, the bulbus duodeni and the pancreas overrunning into the islet cells of the pancreas and the epithelium of the bile ducts.

At the same time, we find this squamous epithelium in the bladder, the renal pelvis, the vagina, the cervix, the milk-ducts and the rectum. All the areas covered with this kind of epithelium are very sensitive and connected to the sensory centre of the cerebrum. They all have typical 'cerebral conflicts' (HH's in the cerebrum).

The earlier periosteum epidermis, which was at one time made of squamous epithelium and sensitive nerves, also belongs to this group. Although the squamous epithelium can no longer be identified there since it would have no function, the sensitive nerves are still found. The periosteum hurts if it is stretched and this invariably happens in the healing phase when the bone edematizes. This is a good sign and an important occurrence in the healing of bone, because the pain forces the individual to rest the affected area of the skeleton that is highly prone to fracture at this stage. We often find endodermal layer tumors that push their way through the squamous epithelial mucous membrane of the rectum. We call these 'polyps' (adeno-Ca).

7.1.1.2.1 Ulcus ventriculi and ulcus duodeni (Stomach and duodenal ulcer)

After personally interviewing some top embryological experts, I am now positive that: the rectum-mucosa (up to 12 cm from the anus) and the vaginal mucosa, the cervix, the mucous membrane of the urinary bladder and the renal pelvis, the upper two thirds of the epithelium of the oesophagus with the small curvature of the stomach, the islets of the pancreas and the bile ducts of the liver and the intima cells of the coronary arteries and coronary veins (very sensitive) are all of ectodermal origin.

They all have squamous epithelium or flattened epithelium and are all invaginated from the outside, from 'migrating' mucous membrane. (Cerebral ectodermal migration!)

I noticed a fundamental connection between the ulcus ventriculi (stomach ulcers) and the ulcus duodeni (duodenal ulcer) that gave me several headaches until it later became obvious. In hindsight, it is clear to everyone that stomach and duodenal ulcers have psychological origins. I do not find this unusual since, ultimately, everything is directed from the brain computer. However, the stomach ulcer and the 'facies gastrica', the stomach 'face' so familiar to every doctor, do not fit at all with the brain-stem directed organs of the gastric area. Neither does islet cell cancer-equivalent (insuloma) of either the alpha or beta cells, or a certain type of liver cancer (liver-duct-Ca). On the other hand, there are cauliflower types of stomach cancers big enough to fill the stomach cavity. How can this contradiction be explained?

We must now recall some known facts, which cannot be explained:

1. Gastric ulcers or duodenal ulcers almost never affect young feminine women (unless they are left-handed).
2. It is very seldom that young feminine women suffer from liver-ulcerated-carcinoma (unless they are left-handed).
3. Stomach ulcers always occur in the same place - at the pylorus (pylorus/bulbus) and in the small curvature; never in the fundus or in the large curvature.
4. The top two thirds of the oesophagus are covered with squamous epithelium, the lower third more by intestinal epithelium. However, the squamous epithelium often goes up to the stomach and sometimes even behind the so-called cardia.
5. Rectal carcinoma and liver ulcerated carcinoma are unusually frequent.

When all these little mosaic stones are put together, it becomes highly likely that, through evolution, parts of this squamous epithelium developed out of the oral mucosa (ectoderm!) into the digestive tract, with its outgrowths, the nervous fibres, all the way to the duodenum, the pancreas (islet cells) and into the liver. The fibres did not migrate further, and this is also the reason why there is only one small intestine carcinoma, the small intestine being, from the point of view of evolution, a belated adjunct between the duodenum and the caecum. It has a relatively small relay centre in the brain stem in comparison to its size or length and is associated with an indigestible life conflict. I am sure that all sensitive nerve fibres innervating the small curvature of the stomach, the

pylorus and bulbus area of the stomach and duodenum, the papilla and pancreatic duct and the cystic choledochus duct, as well as the hepatic duct, are all connected to the right post-centralis lateral lower gyrus. This is so for the stomach, the liver and the pancreatic ducts, the sensitive innervation for the pancreas-islet cells coming, after all, from the midbrain: on the left, para-medial alpha cell relays for glucagon insufficiency (fear/revulsion-conflict); on the right, para-median, beta islet cell relays for diabetes mellitus (resistance conflict).

After stumbling on such a hot clue, I reviewed all my brain CT's and found - especially in left-heart-infarctions – that I had made a huge error. Patients frequently had two HH's, one typical for coronary-ulcus-carcinoma or intra-bronchial carcinoma on the right peri-insular, and another which I had been unable to classify, but which I had interpreted to somehow be part of things. This one, however, always lay in the latero-basal portion of the post-centralis gyrus of the sensory cortical centre on the right.

It became routine to establish from the patient chart whether or not they had complained of stomach problems (which I had mistakenly diagnosed as 'accompanying music' for angina pectoris of coronary carcinoma). In most cases I noted, the patient also complained of severe stomach difficulties, colic, vomiting, tarry stools or such things, which doctors put down to 'gastro-cardiac-syndromes' of heart pain.

If we visualize the nature of an ulcer, its essence is substance loss. An analogous development can be found in all squamous epithelium carcinomas - mouth mucosa, intra-bronchial mucosa, coronary mucosa, bladder and rectum mucosa, and in the case of bladder and rectum, mixed with polyps – which all belong to the mesodermal intestinal epithelium and have adeno-carcinoma tissues!

There can be no doubt that gastric and duodenal ulcers belong to the squamous epithelium ulcers; they are of ectodermal origin, have their relay centres in the lateral post-central retro-insular right gyrus and are a typical attribute of masculine behaviour.

It is really not difficult to understand. There are overlaps of two epithelial formations in the lower oesophagus: at the small curvature of the stomach, at the pylorus of the stomach exit and in the duodenal bulbus and in the pancreatic duct, choledochus and liver ducts. The intestinal epithelium, developed from the endoderm, belongs not only to the stomach-intestinal tract but also to the younger squamous epithelium linked to the ectoderm, the outer germ-layer with its relay centres in the cerebrum. That is why there is pain in cases of gastric or duodenal ulcers and gall-bladder colic. This is also the reason for the innervation of the islet cells (co-migrated) through the mid-brain (the islet cells are innervated directly and directed from the midbrain!)

In the past, many authors of medical textbooks believed that gastric acid was the cause of gastric ulcers. But the biggest cavity in the stomach, where most of the acid permanently sits, never has an ulcer. Apart from this, the hyperacidity of the stomach is already an indicator of vagotonia, as shown in any medical textbook. No one will disagree that gastric ulcers are related to conflicts. However, it is somewhat difficult to understand that there can be two types of cancer in the stomach, an ulcerative cancer and a cauliflower type of cancer. A stomach ulcer is like an ulcer of the mouth mucosa - damaged cells are rejected because their functional inadequacy makes them incapable of meeting mechanical requirements. This explains the 'loss of substance', the substance deficiency. Furthermore, the oesophagus and the stomach have their relay centres (therefore their HH's) in almost the same place. These conflicts are always territorial.

So what about liver cancers? In the liver there are also two types of swellings. One type, with 'substance defect', sits in the bile ducts fed by sensory nerve fibres coming from the cerebrum. The other makes bumpy knots peripherally in the vicinity of the liver capsule

(Glisson's capsule) that can easily be palpated. They resemble an intestinal tumor. The solitary liver carcinoma can only disappear if caseated and destroyed by tuberculosis in the healing-phase. The remaining liver-caverns collapse in the usual way and harden into a so-called solitary liver cirrhosis (in principle the same development as the caseinating cavern forming lung circular foci of the alveolar domain).

The stomach and duodenal ulcer has another peculiarity:
Since the relay centre is located in the cortex, it generates a gastric epilepsy after the destruction of the post conflictolytic edema! In my opinion, stomach conflicts with cramps are often, or maybe most of the time, an epileptic crisis after resolution of a conflict. Since 'cerebrum-stomach' conflict is evidently very related to territorial conflict often appearing jointly with it, the clinical picture of stomach colic was often a veil for the picture of a heart infarction. In less dramatic cases, the 'hepato-gastro-cardiac-syndrome' was referred to, depending on what caught the attention or was highlighted. This must be differentiated from intestinal colic in the healing phase after occurrence of muscular intestinal paralysis (paralytic ileus). Conflict: to be unable to push a 'morsel' peristaltically forward, i.e. unable to digest the 'thing'.

It is well established that a carcinoma in these areas never spreads into the adjacent organ, it can never cross the 'organ threshold'. We never see a rectal carcinoma extending into the sigmoid, or a cervical carcinoma going into the corpus uteri, or a renal pelvic ulcerated carcinoma extend to the collecting tubules (endodermal) or from there extend to the glomeruli of the parenchyma (mesodermal) of the kidney or an upper oesophageal carcinoma to the large curvature of the stomach.

The relay centres for organs with squamous epithelium-mucosa, which at first glance have no relation to the recto-vagino-vesical organs, are located in this same brain region peri-insular on the right: mouth cavity, oesophagus and bronchial mucosa and the intima of the coronary arteries. These are organs that at first glance have nothing to do with each other or with recto-vagino-vesical sexual or territory marking organs.

There were no contradictions in this area for embryologists as long as the triad of the IRON RULES OF CANCER were unknown. Since we now have to discover the exact correlation between a biological conflict, localization in the brain and relation to the organ realm from an evolutionary point of view, we also have to understand the correlation between brain localization and histologic structure from an evolutionary point of view.

We understand that the pharyngeal artery has special status among arteries because its vesicular intima is made of squamous epithelium (very sensitive), it is assigned to the peri-insular region in the brain and is related to territorial conflict contents. We can now understand why there was often confusion in the past regarding the similarity of glioma cells and keratinizing squamous epithelium cells, when the glioma cells built 'glioma scar tissue' (mesodermal) - the so-called 'glioma'. Certainly, the outer skin (epidermis) is also ectodermal, but the entire skin originates from an evolutionary point of view from two different 'skins', an older one, mesodermal 'cerebellar skin', today's 'under-skin' with sudorific and sebaceous glands and a great sensitivity to stimulation, and the younger 'cerebral skin' (epidermis) with squamous epithelium and 'fine' sensitivity.

Explaining the details in a convincing manner will be the task of future researchers, but this will not change the overall system.

Organs directed by the cerebrum and those directed by the old-brain behave in opposite fashion, the reverse of each other with respect to cell-multiplication and cell-reduction during the sympathicotonic and vagotonic phases. While old-brain directed organs generate cell-multiplication during the conflict-active phase, the cerebral directed organs

display cell loss during the conflict-active phase. In the vagotonic healing phase exactly the opposite occurs. This was unknown; not even suspected.

Since all cell-multiplications were regarded as tumors, including those in the red group (cerebrum) which are actually totally normal restitutive cell-multiplications signalling the healing phase, i.e. organ tissue replenishment following a necrosis (for example callus sarcoma after bone osteolysis) in the same way as the cell-multiplication of the yellow group (old-brain - for example colon cancer) in the conflict active phase, no serious researcher could make sense or find any uniformity. The less serious thought there was no possible correlation between these totally opposing groups. Other than the fact that both groups create cell division at some point, although in different phases and for entirely different reasons, there was nothing in common between these different cell multiplications, only that they were the opposite of each other. However, that escaped everyone's notice.

1. We were not interested in the psyche and its conflicts or even real biological conflict in connection with cancer, and we thought it sufficient to trust in the obvious histological 'facts': was it malignant or not malignant?
2. We were only looking for brain tumors or evidence of metastasis in the brain CT's instead of relays in the computer of our brain, and did not want to know anything at all of HH's, since these would have thrown all of medicine on the trash heap.
3. If we had ever consciously shaken hands with the patients with cancer or a cancer-equivalent, it would have become evident that the yellow, old-brain group makes cell-multiplication with cold hands, and the red, cerebrum group makes cell-multiplication always with warm hands.

It would have been that easy!

In the apparently cytostatic chemo-'therapy', it is also impossible to distinguish between the different germ-layer associated properties, otherwise it would occur to some oncologists that 'chemo' can only be effective in the healing phase, and then only by inducing an interruption of the healing. But in the disease phase, 'chemo', which is strongly sympathicotonic in its action, only assists the progress of the cancerous illness.

The ontogenetic system of tumors and cancer-equivalent diseases is valid for cancers, and, together with the five biological laws, is accurate for practically all known diseases. Diseases that do not show tumors or necroses in the conflict-active phase are called cancer-equivalent diseases. I will deal with them in the next section.

7.2 The cancer-equivalent diseases

The ontogenetic system of tumors and cancer-equivalents is applicable not only to cancers but also to cancer-equivalent diseases:

With the yellow, old-brain group, all diseases are equivalent to cancer and its corresponding healing phase in the event that it occurs. 'In the event that it occurs' means that it does not happen unless there is conflict resolution, otherwise the conflict active phase ends in cachexia with the death of the patient or, the patient creates a *modus vivendi* by way of a hanging conflict. The two-phasedness of diseases, from the point of view of the second phase, is dependent on a conflict resolution.

For old-brain organs there is no cancer-equivalent, only cancers and, in positive cases - a healing phase after resolution of the conflict.

For mesodermal cerebrum directed organs (bones, cartilage tissues, lymph-nodes, etc.) there are no cancer-equivalents either, but only cancers in the form of necroses, osteolysis,

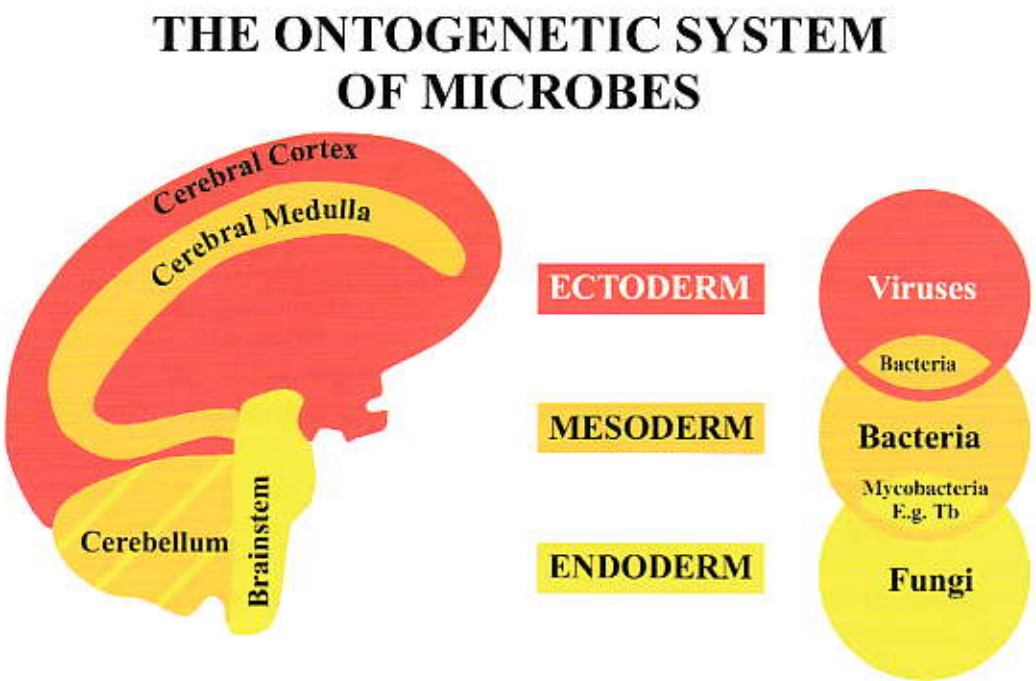
tissue-holes. In short: cell meltdown or degeneration and, in positive cases of conflictolysis, a healing phase with replenishment of the substance-deficiency.

Cancer equivalent diseases are only found in the ectodermal cortically directed illnesses and even there, only for some of those organs. Even so, there are many of them.

The definition states:
Cancer equivalent diseases or cancer-equivalents are ectodermal cortically directed diseases which occur according to the five biological natural laws, except that instead of showing a cellular or parenchymatous substance defect - specifically, cell meltdown - they show a functional impairment. Motor paralyses fall into this category as do diabetes, glucagon insufficiency, visual and hearing impairments with their corresponding conflicts, HH's in the brain and, if there is a conflict resolution, a healing phase with its symptoms and (occasionally, even deadly) complications.

Even if the cells of the organ do not dissolve during cancer-equivalent diseases, they seem to be changed from a given point of view, as are the corresponding brain (HH's) locations. (For example insuloma in the pancreas or glucagon insufficiency). In spite of these changes and even after years of conflict, these cells seem to be functionally restorable once there is a resolution.

7.3 The ontogenetic system of microbes



Correlation between

BRAIN - BLASTODERMIC LAYERS - MICROBES

On the left of the picture is a diagram of the brain and on the right the corresponding microbes that, under orders from the brain, begin to work once there has been resolution of the conflict.

Fungus and myco-bacteria (yellow), the oldest microbes in our organism, work only on the tumors of organs of the endoderm (inner germ-layer) directed by the brain stem. These

have cell multiplication, as in intestinal tumors, as well as the cerebellar directed tumors of the organs of the cerebellar mesoderm (middle germ-layer) also with cell multiplication, for example a tumor in the female breast; also all tumors directed by the old-brain.

Viruses, the youngest microbes (red), work exclusively on the ulcera of the organs of the ectoderm directed by the cerebral cortex (outer germ-layer), as in an ulcer of the nasal mucosa.

In between are the **bacteria** (orange) which work on both the cerebellar directed tumors of the mesoderm (middle germ-layer) where they destroy cells, and the cerebral medulla directed necroses of the organs of the mesoderm (middle germ-layer), where they help in cell restoration, as, for example, in bones.

'The ontogenetic system of microbes' is neither a theory nor a hypothesis, but an empirical finding.

The principle was really quite simple:
After first becoming familiar with the ontogenetic system of tumors and cancer-equivalents, and since I was not totally blind, the ontogenetic system of microbes fell into my lap. When I understood that the biology of humans and animals is neither senseless nor haphazard, as had previously been imagined and that there were no pointless or random cancerous growths or senseless or randomly occurring microbes, I began to look for a system in my NEW MEDICINE. I ended up coming face to face with the following natural laws:

1. The division of microbes: fungi - bacteria - viruses correspond to their ontogenetic age: the fungi are the oldest, the bacteria are next, and the viruses are the youngest.
2. The division of microbes conforms to the germ-layer-correspondence of the organs in which they function.
   a) fungi and myco-bacteria work in brain stem directed endodermal organs.
   b) myco-bacteria and bacteria work on mesodermal, cerebellar directed organs, and bacteria work on cerebral medullar directed mesodermal organs.
   c) viruses work exclusively on ectodermal organs directed by the cerebral cortex.
3. Without exception, all microbes become active only in the second or healing phase, starting with the conflictolysis and ending with the completion of the healing phase; they do not set to work either before or after. They formerly existed as apathogenic germs, can be considered as virulent germs during the healing phase and then again become apathogenic germs.
4. Microbes are all more or less specialized, not only in view of the organs they work on but also in view of the way and style in which they work.
   a) Fungi and myco-bacteria are destruction crews, i.e. they destroy brain stem directed tumors (adeno-carcinomas) and mesodermal, cerebellar directed tumors (adenoid-carcinomas); more precisely - they caseate tumors directed by the old-brain starting at the moment of the conflictolysis, if it happens.
   During the normotonia, the conflict-active sympathicotonic phase and in the renewed normotonia (end of the healing phase) they are apathogenic, therefore harmless. In the same way, they are harmless for all other organs!
   b) Bacteria function as cleanup-workers for the organs directed by the cerebellar-mesoderm and for mesodermal organs directed by the cerebral-medulla, i.e. they work on the entire mesodermal organ domain, but with differentiable function. They destroy the adenoidal tumors of the cerebellar mesoderm but rebuild the cerebral-mesoderm (medulla) directed cellular meltdown of organs such as necroses (osteolyses, etc. - suppurating-granulating-scarring). Their work too starts with

conflictolysis and finishes with the end of the healing phase, specifically with the beginning of the renewed normotonia.

c) Viruses are simply construction or reconstruction workers. They bring about significant swelling and re-fill the ulcers and the organs' losses of cellular substance directed by the cerebral cortex. They too, like the other microbes, are only active during the healing phase. With squamous epithelium ulcera cures brought about by viruses in the case of tubular organs (bronchia, coronary arteries or coronary veins, old pharyngeal ducts of the neck, intra-ductal milk duct ulcers or intra-hepatic bile-duct ulcers) they become temporarily blocked by swelling. In principle the same occurs, but less drastically without virus (for example non A- non B- hepatitis).

5. Microbes, our helpers, are directed by the brain. They have worked for us, not against us, as faithful servants over umpteen billions of years of evolution.
   These dependable microbes are programmed with our organs to respond to the relays of our brain computer. There are therefore neither mycoses in the epidermal layer of our skin nor viral inflammations in the intestine. On the contrary, viruses work according to plan in the healing phase after the (territorial anger) conflict active phase which causes ulcers of the intra-hepatic (ectodermal) squamous epithelium, with strong occluding swelling of the intra-hepatic bile ducts, generally referred to as (viral) hepatitis.
   The distinction between icteric and anti-icteric (jaundiced or non-jaundiced) describes how many bile ducts are occluded, or whether or not the main duct (choledocus) is occluded through swelling.
6. If there are no special microbes, healing occurs anyway, but not to the biological optimum. This means a death fright conflict with pulmonary circular foci heals after conflictolysis with myco-bacteria tuberculosis through caseination and collapse of the circular foci. On the other hand, the same circular foci (adeno-Ca) without myco-bacteria-tuberculosis are encapsulated in scar tissue. However, the build up of caverns after caseination and expulsion through coughing of the tumors is biologically more optimal.
   This is also the way in which intra-hepatic bile-duct ulcers heal after resolution of conflict in the absence of viruses (non A- and non B- virus hepatitis). When there are hepatitis A or hepatitis B viruses, the development is shorter but more fulminant, and evidently offers, from a biological point of view, a higher chance of survival than without virus. It is not the viruses that bring about the hepatitis, as we thought, but rather our organism that uses them to optimise healing, if they are available.

Another aspect that provokes questions:
So-called **'dangerous infections'** - especially from exotic microbes - occurs only during the healing phase. There are no virulent microbes present without a healing phase, only a very specific group of microbes. This principle has hopefully by now become clear. However, our brain has no program to deal with cars and planes just as a deer's has no program to deal with bullets shot from a distance of two kilometres; in the same way, our brain is not programmed to deal with travel over thousands of kilometres or to live in places with very different climates and microbes. What is normal for the long-term inhabitants of Central Africa is not normal for outsiders; the population living there since childhood is adapted to the environment. Measles, experienced by children living in Europe, was fatal for the adult Indian population in North America, but not for the Indian children. Without doubt, the measles virus is transferred, but only those adults or children who have experienced the corresponding conflict and are at the moment undergoing the healing phase become sick. In the case of measles, it is a conflict content of the mouth or sinus („this stinks").

This ontogenetically conditioned system of microbes will change all of medicine from the ground up. The micro phobia current in medical circles is a monument to the soullessness and sterility of contemporary medicine.

7.4 Summary of the biological natural laws and the biological rules

We recognize five main biological natural laws in NEW MEDICINE and six biological rules, which may or may not ultimately become natural laws unless exceptions are found.

The five biological natural laws are:

1. THE IRON RULE OF CANCER.
2. The Law of the Two Phases of all diseases provided there is conflict resolution.
3. The ontogenetic system of tumors and cancer-equivalents.
4. The ontogenetically conditioned system of microbes.
5. The quintessence of the four preceding natural laws of the NEW MEDICINE.

The six biological rules state:

1. There is an epileptic or epileptoid crisis in the course of all healing phases, especially in short-lived conflict-relapse.
2. Left and right-handedness and its consideration for the localization of HH's in the brain and the location of the corresponding symptoms in the organs.
3. The 'depressive constellation' (hormonal stalemate and active territorial, territory-fear or territorial anger conflict) or 'manic constellation' (hormonal stalemate and active female sexual frustration conflict, identity conflict or shock fear conflict).
4. The brain sided succession of the HH's in the conflict active phase in the cerebellum and the cerebrum.
5. The generation of schizophrenic constellation through two conflict-active cortex directed HH's.
6. Uniformities in the course of healing in cerebral directed organs, such as bone cancer in the healing phase (leukaemia).

8 The Terminology of the NEW MEDICINE

In order to avoid misunderstandings from the start, it is very important to explain the language and especially the terminology of the NEW MEDICINE. Given the entirely new perspective and the terminology developing from it, language problems may arise between the current medicine and the NEW MEDICINE. An inherently systemic way of thinking is a necessary prerequisite to understanding and utilizing its natural laws and all its diagnostic, therapeutic and generally human implications. The purpose of this chapter is to clarify this.

The terminology of official medicine implicitly embraces dogmatically accepted hypotheses and cannot distinguish between facts and prognoses because the latter comprise hypothetical claims. It is because of this that we cannot adopt the standard terminology in its broadest context and, as a result, the NEW MEDICINE has had to create new terminology, an entirely new language.

We do not doubt the *factual* findings of official medicine. What we challenge are the connections and inter-relations that are made in arriving at those findings, the so-called diagnosis in which an evaluation of the facts is implied. A diagnosis of 'metastasis', for example, implies an unverified, if not misleading, hypothesis concerning a secondary cancer, thought to be a 'metastasis' of the primary carcinoma. The fact that there is a second or third carcinoma is not in dispute, at least, not in principle; what we *do* challenge is the *evaluation* of this indisputable fact.

Our lack of information regarding causes left no alternative but to create working hypotheses that, through habit and uncritical acceptance, led to their becoming truths. Countless hypotheses have been postulated to explain why alleged apathogenic benign mycobacteria, under certain conditions, could all of a sudden become pathogenic or malignant. In fact, the mycobacteria themselves are absolutely identical. The working hypotheses, however, had implicit consequences that were never demonstrated.

The so-called **'metastases'**

Example: a right-handed woman suffers a DHS because her child is suddenly sick. After three months in hospital, the child recovers. The mother, however, is found to have a 1.5 cm mammary gland carcinoma in the left breast. She is told that the entire breast has to be amputated because of the danger that the malignant cells will 'spread' to the surrounding area or may even swim through the blood and generate 'distant metastases'. In order to prevent this, chemotherapy should be administered as soon as possible to kill all the malignant cells. Confronted with this frightening diagnosis, the surgical interventions, the implications and the prognosis, the young mother suffers the following DHS's:

1. A disfigurement conflict: a melanoma in the surgical scar of her previous left breast.
2. A self-devaluation conflict: rib osteolysis in the area of the left amputated breast („I won't be productive there any more" or „I'm useless there").
3. An attack conflict against the left breast area to be operated: a pleuro-mesothelioma of the left pleura.
4. A death-fright conflict: pulmonary circular foci (adeno-carcinoma).

Some of the organ changes associated with these conflicts are noticeable fairly early on: the melanoma and the circular foci in the lung, and, because the child is already better, the distant 'metastasis' in the right lateral cerebellum, which is really an HH in the post-conflict resolution stage.

Rib osteolysis and pleura discharge are usually first noticeable after a conflict resolution.

Since some of the supposed 'metastases' appear in the vicinity of the amputated breast, it was customary to think that cancerous cells somehow migrate to the new location (working hypothesis). These local foci have been designated 'proximal metastases'. If the corresponding HH is found in the brain - because the supposition is that the 'malignant cells' travel via the (arterial) blood to the brain - these are called 'distant metastases'. These hypotheses have become dogma, despite the fact there has never been a single observation of cancerous cells in the arterial blood stream. It is curious that these 'malignant cells' always form the appropriate cancer type and precise histologic configuration corresponding to the location to which they migrate. So, in most cases, (yet another hypothesis), they must undergo a metamorphosis along the way. To do this, they must have a brain (hypothesis) in order to know the exact type of histological structure they should build at their destination. There is an additional difficulty with ulcerations and necroses: how are the 'malignant cells' emitted, given that in cell loss there are none to be found? We were always looking for a 'primary tumor' of the old-brain type (further hypothesis), which could be seen as the so-called 'primary focus'. Yet, up until now, no one had noticed that essentially benign ulcers or necroses of various organs (e.g., stomach ulcers) suddenly, as if by a stroke of bad luck (in the PCL phase), become 'malignant'. Given this train of hypotheses, the 'metastatic' benign osteolysis becomes a raging 'malignant' osteosarcoma.

Thanks to the NEW MEDICINE, patients can now understand what is happening to their bodies and should not panic in response to the frightening multiplicity of hypotheses regarding the unexplainable, senseless and unstoppable developments with which they are faced. As a result, they will not develop secondary carcinomas in most cases and will be able to survive these special programs of nature.

In the area of prognosis, the discrepancy between the old medicine and the NEW MEDICINE is even more noticeable, especially regarding the grounds for prognoses. In the NEW MEDICINE we know that the way in which a patient hears a prognosis can result in several further conflict-shocks, with their own DHS's, rendering the prognosis a self-fulfilling prophecy. This can be proven in countless cases. The solution is simple: the NEW MEDICINE must be explained to the patient. Once he has been told what he has and why, the diagnosis and prognosis are neither frightening nor terrible and the patient does not suffer second conflicts leading to 'metastases', which significantly raises his chances for survival. Patients have suffered this awful panic because they have been convinced by doctors to believe in the unpredictability of cancers and of the so-called 'metastases'.

I shall never forget some poor patients at the Heidelberg University Clinic, eyes wide with fear, who were told by the head professor on one of his visits that „there is nothing else we can do ... you are going to die ... but we'll make it painless..." The patients felt total panic after this 'final prognosis'; they stopped eating and drinking - something they could no longer do in any case because of the morphine they had been receiving - and then they died shortly after. As a result of my recent discoveries, I am now convinced that half of those unfortunate patients only had healing symptoms. If we had done nothing and not created any panic, many of them would have healed, as we say, 'spontaneously'. I have been pointing out this phenomenon since 1981. It was not until 1989, for the first time, that U. Abel of Heidelberg, in his booklet '*Die zytostatishe Chemotheraphie fortgeshrittener epithelialer Tumoren*' (*Cytostatic Chemotherapy of Advanced Epithelial Tumors*) cautiously remarked that we should at least test what would happen therapeutically if we were to do nothing, by comparing statistical increases in controlled groups.

Many carcinomas appear in a new light in view of their correspondence to the three germ layers in embryology. Since everything that generates cell-multiplication is not viewed as a tumor, there are important new dimensions regarding prognosis. For example:

A bronchial carcinoma is the result of an ulceration of the mucosa of the bronchia - what we used to call a 'bronchial carcinoma' but is actually a temporary atelectasis (lung collapse) - indicating a healing phase of the ulceration. Since the swelling of the mucosa blocks the bronchus, and since all violent coughing is the same in principle, namely, the result of a swelling of the mucosa in the healing phase of bronchial ulcers after a definite kind of frontal fear conflict, then it is evident that we have a language problem. The NEW MEDICINE has had to find a new language, one that is free of the ballast of the 'official medicine' terminology that sticks to its diagnoses and prognoses.

Biology and nature do not harbour benevolence or malignancy; nature intends only meaningful, goal-oriented, sensible and focused solutions (even though they may be through apparently incomprehensible or bad things). The problem is that we do not understand the process. Nature does not forget or make mistakes and become rudderless, mutated or run amok.

It is for this reason that the terms 'benign' and 'malignant' are not used in the NEW MEDICINE.

There are no 'metastases', but only secondary, tertiary, etc., carcinomas. Neither are there 'brain tumors', but only HH's in target-shot configuration, or brain edema or neuroglioma tissue concentration after resolution of a conflict. There are no more 'infectious diseases', but only healing phases after a conflict-active period with corresponding brain localization and appropriate organ manifestation of the corresponding cancer or cancer-equivalent disease with the participation of the necessary microbes.

On the other hand, we now have the DHS (Dirk Hamer Syndrome), marking the beginning of the biological illness; there is a CL (*Conflicto Lysis* - conflict resolution), indicating the start of the healing phase, and an EC (epileptic or epileptoid crisis) at the apex of the healing phase. All these are provable and predictable facts (excluding the DHS which catches us unaware and on the wrong foot.) In what follows, we briefly define and explain the most important concepts of the NEW MEDICINE alphabetically: All designations of 'biological conflicts' are chosen in such a manner that they simultaneously have meaning for mammals (real) but ultimately also have meaning for us, in a transposed, language-mediated sense.

8.1 The terminology of the NEW MEDICINE

Allergy:
Allergies do not exist in the sense we have hitherto understood them. Allergies confirmed with regular allergy tests are always second-track developments connected with some DHS (see under 'tracks').

Bi-hemispheric constellation (Schizophrenic cerebral constellation):
There is a difference between a bi-hemispheric cerebellum constellation and a bi-hemispheric cerebral-cortex constellation. The bi-hemispheric cerebellum constellation derives from a very specific conflict development. For example: it is only when a woman-and-mother suffers a mother-child-worry or argument-conflict and also experiences a partner-worry or argument-conflict, that she can be in constellation of the cerebellum for the duration of the conflict activity. This becomes very evident on the emotional plane: „I am burnt-out"; „I no longer experience human emotions". The patient is emotionally paranoid, but her formal logical thinking has not been disturbed. There can be various conflicts affecting the same hemisphere in the cerebellum. There are then several active conflicts but no constellation. On the cerebrum medulla as well there can be several

conflicts impacting on the same side, one after the other, because the conflict contents map them into that area.

It is very different, however, in the realm of the cerebral cortex, even with respect to ductal mammary carcinoma, regarded as an exception, which seems to be coupled strongly with the cerebellum. A separation conflict from a partner in a right-handed woman will frequently produce a ductal ulcerated carcinoma of the right breast and affect the right side of the brain, even though this should already be blocked with, for example, an identity-conflict. There is a different order of events in cerebral-cortex conflicts, the sequence of which follows a definite rule: a territorial conflict in a right-handed man with brain localization in the right-periinsular relay corresponding to the coronary arteries 'closes' the right cortical hemisphere; this hemisphere is then saved from a second active biological conflict. In the event of a second cortical conflict - and only in the event of one of these - it will strike the left side. This is then called a bi-hemispheric schizophrenic cerebral-constellation. (See the section on psychic, emotional diseases).

Biological conflict:
Any conflict of man or mammal resulting in a DHS. From a merely evolutionary point of view, biological conflicts are identifiable as archaic conflicts, analogous, in principle, for man and mammal. Animals experience most of these conflicts in real, physical terms, whereas man often does so in a transposed sense. An animal genuinely finds a morsel that it cannot swallow, a real chunk of food. For a person this might be a valuable coin or a lottery ticket. All relays in the brain stem refer to conflicts concerning grabbing the morsel, swallowing it, digesting it, separating it from the filth, etc. In the case of a 'refugee' (existence) conflict, cancer of the kidney collecting tubules protects the organism from drying out; the urine becomes highly concentrated.

Brain edema:
The intra and perifocal edema in the HH must occur in the PCL-phase. In a so-called hanging-healing situation, it is possible for an HH focus to increase instead of decrease in the second half of the PCL-phase. We then say that the edema 'swings itself high'.

Brain tumor:
This is the incorrect description for an HH in or after the PCL-phase. The necessary but harmless glia storage is incorrectly identified as a 'malignant tumor'. The glioma reserve is an advantage in the repair of the HH, allowing it to heal in a thoroughly biological fashion; the tissue becomes fully functional and returns the brain to its normal rhythm. The biological disadvantage in this healing is that the brain tissue is no longer in its original (virgin) condition, and is more rigid than before. A relapse, which is always possible, can cause a tissue rupture (a so-called cyst). On the other hand, a brain that has been operated on or a brain affected by any other injury, will never again work in its normal rhythm. This concurs with our experience of brain-injured soldiers and war victims who usually only need one conflict to go immediately into a bi-hemispheric constellation where they say and do things for which they cannot be held responsible.

CA-phase:
Conflict active phase; lasting sympathicotonia, cold skin, cold extremities, sleeplessness, lack of appetite, dwelling constantly on the contents of the conflict. Presence of an HH in the brain in sharp, concentric, 'target' configuration. At the organ level, there is cancerous growth (old-brain directed organs), necrosis or ulcerous growth (new-brain directed organs).

Cerebral castration:

In the case of a biological territorial-conflict, territorial-fear-conflict or territorial-anger conflict for males, the following will happen:

a) Right-handed man: the conflict affects the right temporal relays;
b) Left-handed man: the conflict affects the left temporal relays.

Should it last a long time, there is a possibility that the highly acute conflict will be transformed into a hanging-active territorial conflict. In the case of (a), the individual ends up working with the left 'female' cortical hemisphere and becomes soft (platonic) and homosexual (second-wolf-phenomenon). In the case of (b) the left cortical hemisphere is blocked and the individual becomes 'doubly masculine' from a brain hemisphere point of view; in spite of that, he is psychically castrated, and becomes a macho homosexual (the 'male' partner in the homosexual relationship).

The same happens with women but in reverse in a sexual conflict that cannot be resolved (and also with territorial fear and identity conflicts):

a) Right-handed woman: there is a block of the left side - immediate amenorrhea. The patient functions with the right 'masculine' cortical hemisphere, and becomes more masculine (also platonic) and a lesbian type.
b) Left-handed woman: blockage of the right cortex - no amenorrhea, but although she becomes doubly feminine, she is still psychically-sexually blocked. The biological conflict could have occurred at a very early age, giving the impression that she was always homoerotic or particularly predisposed that way, which in this case would seem to be correct.

CL:

Conflicto-lysis, conflict-resolution of the biological conflict. Turning point from the lasting sympathicotonia to the lasting vagotonia, specifically from lasting day-rhythm to lasting night-rhythm or from stress-phase to rest-phase.

Conflict-contents:

The biological conflicts are all archaic conflicts, affecting both humans and animals in an analogous way. Earlier on, we thought that only so-called 'psychological conflicts' (psychological problems) were important, but we were wrong. It is the biological conflicts only that transform and change the brain, both in man and animal. The naming of the conflict-contents attests to the fact that these conflicts must be virtually 'inter-animal', at least for us mammals. For this reason, there are designations such as 'ugly- indigestible conflict' in cancer of the colon, 'ugly-partially-genital conflict' in the case of prostate cancer or cancer of the mucosa of the womb. Half-genital means that the conflict does not concern only the genital realm (in a real or transposed sense), but evokes the genital theme as an 'accompaniment', which distinguishes this conflict clearly from the sexual ones. All these conflicts presuppose a strong understanding of evolutionary history. The biological conflict of 'feeling disfigured, injured or attacked' can therefore be understood when it leads to melanoma or, in the case of cortical conflicts, territorial-conflict, the female sexual conflict of 'being unable to engage in intercourse', the territory-marking conflict (ulceration of the bladder, because mammals mark territory with their urine) or 'separation conflicts' (sensory paralyses with neurodermatitis), 'brutal separation conflict' with inflicted or suffered pain (sensory periosteum paralysis in the PCL-phase or even so-called 'muscular rheumatism') or also 'frontal fear conflict', 'fear in the neck conflict', 'conflict of powerlessness', 'identity conflict', 'conflict of resistance', 'fear, revulsion or disgust conflict', etc.

Animals, our fellow creatures, suffer these conflicts in a very real sense, whereas man does so mostly in a transposed sense (for example, verbal mediation). Basically, there has always been a common biological language between man and animal, especially the

mammal. This is born out by the fact that humans are often closely attached to dogs, horses and cows, communicating and experiencing them as almost human. We suffer the same type of conflict whether a human partner or a dog partner dies. A young sick dog can result in a mother-child conflict for the woman, who, if right-handed, may suffer a left breast carcinoma. Inversely, animals suffer conflicts for people as partners as well. I hope that this knowledge of the conflict contents will eventually open a new era of relationship between man and animal, away from the dreadful perception of animal as object that has resulted in the terrible extermination of many rare animal species and the totally unnecessary experiments on animals that are a particular disgrace.

Conflict-mass:
Conflict mass is the total sum of conflict intensity and conflict duration. Conflict mass indicates whether the individual will or will not survive his healing phase (for example, heart infarction). A territorial conflict of average strength lasting more than nine months, or a very intense six months, leads to a resolution, specifically heart infarction that will, in all likelihood, be deadly. There is one phenomenon that allows for very little conflict mass to accumulate, and that is the bi-hemispheric constellation. A patient with a bi-hemispheric cerebral cortical conflict constellation can have various hanging conflicts bilaterally for fifteen years and will survive a resolution of the conflicts like a heart infarction. With conflicts controlled by the old-brain, the conflict mass is directly proportional to the size of the tumor. It is the magnitude of the tumor that allows one to conclude on the mass of the existing conflict.

Consecutio conflictuum:
the sequencing of the conflict. In the cerebellum, a biological conflict can impact twice on the same cerebellum side, depending on the area the individual feels is under attack. Cortical cerebrum conflicts are different, however. With the exception of the milk-duct, i.e., mammary duct carcinoma in a separation conflict (mother-child separation conflict for right-handed women in the right cortical sensory centre, milk-ducts of the left breast; separation conflict from a partner, milk-ducts of the right breast, the opposite with left-handed women). Should there be an incidence of a second conflict in the opposite cortex while the first conflict is still active, a bi-hemispheric constellation will immediately ensue.

DHS:
A DHS is a highly acute, serious, dramatic and isolating conflict-shock experience, which catches the individual on the wrong foot, (totally surprised). Its unexpected nature is, therefore, more significant than the 'psychological value content' of the conflict.

Epileptic crisis (EC):
Epileptic tonic-clonic attack, the low point of vagotony in the healing phase after a motor conflict. The epileptic crisis is the turning point towards re-normalization that will only be fully achieved at the end of the healing phase. The epileptic crisis is a naturally programmed, necessary, almost imaginary, conflict-relapse in the middle of the healing-phase. The patient re-experiences, in compressed time, the entire biological conflict of the conflict-active phase. Through this, the organism can press out the edemas and re-normalize (with diuresis phase).

Epileptoid crisis:
With the exception of the motor biological conflicts that have an epileptic crisis in the healing phase (PCL-phase), basically all diseases known to medicine have an epileptoid crisis. Epileptoid means: similar to epilepsy. There are no cramp-attacks in the epileptoid crisis as there are for motor conflicts, but each biological type of conflict and disease has its specific type of epileptoid crisis. For example, an epileptoid crisis for a biological

separation-conflict results in an 'absence' (amnesia). The same holds for biological (brutal) separation conflicts with pain manifestations in the periosteum-sensory conflicts. A typical epileptoid crisis of a territorial-conflict with ulceration of the coronary intima (branchial evolution, ectodermal) is heart infarction where we differentiate between the right-periinsular brain directed left heart infarction with the left-periinsular brain directed right heart infarction, which has ulceration of the coronary veins during the conflict-active phase. The right heart infarct is synonymous with a lung embolism and the epileptoid crisis of a cervical carcinoma in the PCL phase. The relatedness of these organs is explained by the fact that, from an evolutionary point of view, humans descend from a ring-formed being. At that early evolutionary stage, these organs were very close together.

Another epileptoid crisis, for example, is the 'lysis' of pneumonia, where pneumonia is the PCL-phase of a bronchial carcinoma. Even the organs controlled by the brain stem have this kind of epileptoid crisis in the PCL-phase, with or without mycosis or TB, i.e., with or without caseation and destruction of the tumor. Standard medicine identifies heart infarction and lung embolism as two separate diseases. Similarly, in the NEW MEDICINE, we know two types of **asthma**, their commonality being that they both reflect a bi-hemispheric constellation. One of them corresponds to a territorial-fear. Territorial-fear can be evidenced in two ways:

a) motor
b) sensory.

Sensory territorial conflicts that show pneumonia in the PCL-phase are called, as already stated, 'lyses'. The motor biological conflict of the bronchial musculature is called, in the case of a bi-hemispheric constellation, asthma. Again, this comes in two kinds: One of them relates to the whole conflict-active phase, the other only to the short epileptic crisis, which, in reality, is a brief intermission reminiscent of the CA-phase.

In principle, the following combinations of conflicts that lead to asthma are possible:

- both biological conflicts are active.
- one biological conflict is active, the other one in epileptoid (left cortical) or epileptic (right cortical, bronchial musculature) crisis.
- both conflicts are in the PCL-phase and have an epileptoid and/or an epileptic crisis.

In the past we could not understand why cortisone only worked with one kind of asthma attack. They were the cases in which the conflict was in a PCL-phase in one or both hemispheres with the attack indicating the one or two-sided epileptic or (left side) epileptoid crisis. Epileptoid crises are the most dangerous moment in the development of the biological conflict for many cerebrum cortical conflicts (heart infarction, lung embolism, lysis of pneumonia, 'absence' amnesia after a separation conflict, etc). Immediately after the epileptoid crisis, in all diseases, we observe the so-called 'pee-pee' phase, or diuresis. Starting with the epileptoid crisis, the organism disposes of the excess water it had stored. Patients can eliminate from three to five litres of liquid. If they know this, they are at ease. If they do not understand the connections, they are distraught because they have lost a few kilos. After the 'pee-pee' phase is successfully over, the organism steers itself back to normal. This last stage is usually uneventful.

Fronto-occipital constellation:
The patient has two active biological conflicts: one frontal, the other occipital. If they are both in the same hemisphere, then this is only a 'fronto-occipital constellation'. If, however, they occur in different hemispheres, it is a 'combined bi-hemispheric fronto-occipital constellation'.

Glioma (neuroglioma):

Mesodermal connective tissue cells in the brain in the PCL-phase in the HH. The glia-cells are not stored for the exclusive use of repairing the HH, but for anywhere in the brain where repair is needed where scar tissue will form (for example, after an operation). The HH is fully functional after repair by glia-cells. However, the price for the repair is that the tissue in the HH is more rigid and not as elastic. Healing after a conflict relapse in the same area becomes much more difficult.

HH (Hamerscher Herd):
Specific brain organ relay that becomes an HH through a DHS. It has a concentric, sharply defined, target configuration during the CA-phase. In the PCL-phase the target-rings edematize. Later there is a local reserve of neuroglioma: glioma-rings, presently diagnosed incorrectly as 'brain tumors' and unfortunately taken out. (Glioma - for example astrocytoma, oligodendroglioma, glioblastoma, etc.) (see also the chapter on Hamer foci).

Hanging-active conflict:
The biological conflict is constantly active, even if transformed to one of less intensity. The patient can live to an old age with such a conflict as in the 'second-wolf phenomenon'.

Hanging healing:
The biological conflict is in lasting resolution, but the resolution never ends because there are always small recurrences of the conflict that prevent a definitive healing, such as in during dreams. Examples: Parkinson's disease, a motor conflict of the hands - not-being-able-to-hold-on-to-something.

Meningeoma:
An HH under the meninges that has healed well. During the PCL-phase, the HH was attached to the meninges, but with no detrimental consequences. It was a mistake to consider this a tumor of the meninges (meningeal-glioma).

Mixed innervation:
Several existing conflicts that are not developing in the same phase. For example, one is in the CA-phase, the other one already in the PCL-phase.

Monocyclical conflict:
A biological conflict with a CA-phase and a PCL-phase. Should the development be interrupted by relapses or resolved by short-term solutions, we call such a conflict course polycyclic. Even if the individual suffers several conflicts, they could all develop monocyclically. If there are phase differences, we speak of 'mixed innervation', meaning that one conflict is in the CA-phase while another is in the PCL-phase.

Old-brain conflicts:
These are biological conflicts that affect organs controlled by the old brain: they are the gastro-intestinal tract (brain-stem) and the organs controlled by the cerebellum; pleura, peritoneum, pericardium and the corium (derma). The brain-stem conflicts are: inability to obtain the morsel, to swallow it, to digest it, to separate it, not wanting to eliminate liquids (kidney collecting tubules in the so-called 'refugee' conflict), ugly partly genital conflict in the womb and prostate carcinoma. The cerebellum conflicts concern conflicts of integrity: attacks against the thorax area (mesothelioma of the pleura), against the stomach, (mesothelioma of the peritoneum), against the heart area (mesothelioma of the pericardium) or against the outer skin - disfigurement or contamination conflicts (melanoma of the corium skin).

Ontogenetic system:
System of tumors and cancer equivalents. One could also call this the phylogenetic system. Ontogenesis is the recapitulation of phylogenesis in the embryonal and infantile stages.

Phylogenesis, albeit very probable, is a theory. Ontogenesis, on the other hand, is an indisputable fact. This is why we call the system ontogenetic. (see appropriate chapter).

PCL-phase:

Post conflictolytic phase: healing phase, beginning in the conflicto-lysis (conflict resolution) and ending with the re-normalization or normotonia. The epileptic or epileptoid crisis takes place at the lowest point of the vagotonic PCL-phase, also called lasting-night-phase.
Cerebrally: edematized dissolution of the sharp, concentric target-shot configuration of the HH from the CA-phase (edema rings, intra- and perifocal edema of the HH.)
Psychically: the conflict is no longer an issue.
Organically: a healing, multiplying growth in the case of cerebral and cerebellar medulla controlled organs. Tumor disintegration by microbes in the case of old-brain controlled organs. All known microbes work exclusively in this PCL-phase, not before, and not after. If we lack microbes, e.g., tbc acid-proof rod bacterium during the PCL-phase, then the tumors are neither decomposed not caseinated. After the PCL-phase, we derive no benefit from tubercular mycobacteria for this particular carcinoma. They could become useful in the case of some later carcinoma, but they will not attack the earlier, inactive carcinomas.

Polycyclic biological conflict:
In contrast to monocyclical conflicts, polycyclic biological conflict developments are frequently interrupted by relapses and have shorter or longer healing phases.

Secondary conflicts:
Secondary conflict refers to the fact that a person undergoes a new DHS as a result of a diagnosis (iatrogenic) that puts him into a panic and a new biological conflict. Because of our lack of understanding in the past, these secondary conflicts were called 'metastases'. If we were to examine the CT's of a hundred dachshund-bitches with teat-carcinomas and the CT's of a hundred women with mammary carcinomas, we would find that both groups have clean lungs on the day of the diagnosis (no circular lung foci). Two months later, however, many of the women, in direct relation to the brutality of the diagnosis, would show circular foci and adeno-carcinoma of the lung. In the case of the dogs, not one will show the same lung foci. The latter, not conversant in our language, did not understand the diagnosis, felt no panic and did not suffer a secondary carcinoma. Secondary carcinomas, 'metastases', are extremely rare in animals.

Sympathicotonia:
First phase of the disease sequence or of the special biological program. The meaning of the lasting (long-term) sympathicotonia is the same as the CA-phase. In terms of innervation; lasting displacement of equilibrium in the direction of the sympathetic nerve ('Grenzstrang' threshold limit of the sympathetic nerve). Symptoms: mydriasis, tachycardia, hyperhidrosis, hypoacidity of the stomach, intestinal paralysis, etc. This was earlier perceived as vegetative disturbance (vegetative lability). The facts were right, but understanding the reasons was missing.

Target configuration of the HH in the brain, target configuration of the organ focus:
It is possible to see the target on the CT's; they are sharp concentric ring configurations in the relays of the brain corresponding to the conflict and specific organ from the moment of the DHS. In the case of compact organs, it is also possible to see one or more of the same type of target configurations on our CT's from the moment of the DHS. While it is possible to see the target configuration on the appropriate HH in the brain during the entire duration of the conflict activity, once the compact tumor develops in the organ (liver,

pancreas, lungs), the target configuration is more difficult to see or is outright invisible. In organs that generate necroses (bones, kidneys, spleen, lymph nodes, ovaries and testes) the configuration is invisible after a brief period, because it becomes a kind of empty space that fills up with liquid. After the PCL-phase, it is possible to distinguish the callus again in bones, the 'frozen' target configuration. The HH in the brain shows the typical target edematization in the PCL-phase, when the entire HH swells up. *The subsequent storage of glia cells that, later, with contrast medium, show the HH white, apparently shows along the rings, as many examples have clearly shown.*

Tracks:
When an individual experiences a biological conflict through a DHS, at the moment of the DHS there is an imprint, not only of the conflict, but also of certain accompanying circumstances. If one of these situations recurs, he may even experience a relapse of the complete conflict. It appears that the side track always leads back to the main track, which explains its name, 'track'. Example: In former days, the first lovemaking almost always took place in the hay. Complications or small catastrophes were frequent on these occasions. If these disasters caused a DHS, the smell of the hay could become a 'track' in the conflict complex. After that, without even thinking, every time the affected person smelled hay, the tracks would be activated again. Most of the time, the first conflict type was 'this stinks'. The re-activated cases that we call allergies, the ones we test with our little patches, regularly caused the patient's hay fever in the PCL-phase. This 'hay-fever' without hay could also have been suffered by the patient in the PCL-phase had he experienced a comparable catastrophe when making love to the same or another woman in similar circumstances. What we have here is an very good, extremely attentive warning system of the organism.

Vagotonia:
Vegetative innervation of the parasympathetic nerve, also parasympathiconia. The meaning of lasting vagotony is the same as that of the PCL-phase. The vagus nerve counts as its own brain nerve, with several branches, such as the nucleus dorsalis, the ambiguus nerve and the tractus solitarii nerve. Vagotony, (as per Eppinger, Haas 1910): Lasting, long-term equilibrium shift towards a higher excitability or a predominance of the parasympathetic system. This was identified in the past as constitutional vegetative lability. Symptoms: hypotonia, bradycardia, miosis, stomach hyperacidity, intestinal colics, increased salivary secretion. What the NEW MEDICINE now calls the PCL-phase was previously observed but not understood; it was therefore misinterpreted and called 'vegetative lability' or dystonia. The fact was incontestable; the *evaluation* of the fact was wrong.

9 The Diseases of the Inner Germ Layer

The textbooks of the future will not classify diseases according to the specialty, but according to their relation to a specific germ layer. This classification is the biological natural order of these diseases or special programs of nature. Classified in this way on our chart makes it possible to determine that there are similarities among the diseases or special programs belonging to the same germ-layer - aware of the distinction between cerebellum-directed and cerebral medulla-directed association for the middle germ-layer - other properties, as well as particular details, specific histological similarities, adjacent locations in the brain, and conflict similarities, organized as if by itself according to the germ layer relationship.

Let us begin with the diseases or special programs of the inner germ layer or endoderm: We see that they are all controlled by the brain-stem; there is even an order in their location, for they begin dorsally on the right, with the diseases of the mouth and the nasopharyngeal space, and then continue in a counter-clockwise direction along the gastro-intestinal tract, ending with the sigma and bladder carcinoma on the left dorsal portion of the brain-stem. This shows a very intelligent ordering between the brain relays and the organs of the gastro-intestinal tract, as well as appended organs.

We see that the conflicts are all similar: they are always concerned with getting the morsel*, swallowing it, transporting it, digesting it and eventually eliminating it.

Histologically and without exception, all carcinomas are adeno-carcinomas. For this reason, they all grow in the conflict-active phase by cell-multiplication and are decomposed by fungi or myco-bacteria in the healing phase.

This order in all three levels and the histology helps us in diagnosis; we will not need exploratory excisions in the future, other than in exceptional cases where the topographical association of the tumor is not clear.

The knowledge gained through the NEW MEDICINE regarding the spontaneous natural destruction of all these carcinomas in the healing phase, will make surgical intervention superfluous for most carcinomas as long as there is a conflict resolution and as long as the patient has fungi or myco-bacteria, i.e., tubercular acid-resistant rods. The diagnosis for the whole therapy will fundamentally change. What seemed correct before is no longer true, even though the facts are the same. An understanding of the meaningful correlation of these facts leads to completely new conclusions. The almost instant conclusion of the histopathologist regarding 'benign' or 'malignant' becomes redundant. We can at last begin to move on biological-scientific assured ground.

The psychological aspect of the biological conflicts requires knowledge of our evolution, to think back on how our organs manifested over time.

The need for the psychologist has become redundant with regard to the psychological aspect of the biological conflicts. The purely intellectual training they are given does not allow them enough imagination to comprehend these archaic conflicts. One must also follow our evolution to be able to understand the organic manifestation.

With a patient who wins the lottery but is unable to collect his winnings, the win should be imagined as the morsel that the patient has put in his mouth but cannot swallow; as a result, he develops an adeno-carcinoma of the gums. An animal would only get an adeno-carcinoma of the gums if it were unable to swallow a morsel of real food. But it does not require much imagination to see the lottery-win as a morsel since people actually do that. During the varying stages of assisting such a patient psycho-therapeutically, we must

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* mouthful, small piece, diminutive of *mors* a bite

continue to keep in mind that these old and archaic progression patterns have a definite meaning which become much clearer if we understand the history of evolution. A patient is told, for example, that he has an intestinal carcinoma that must be operated; on average, two new conflicts develop as a result:

1. An attack against the stomach because it is going to be cut open. A biological conflict of this type causes a peritoneal carcinoma (this will be discussed under organs controlled by the mesodermal layer). The peritoneal carcinoma grows in the conflict-active phase.
2. If the patient suffers a solitary liver carcinoma, specifically dextro-dorsally, this corresponds to the archaic fear that no more food will pass through the intestine because supposedly there is a blockage. It means that the patient has an archaic fear of starvation or of having an ileus growth that will prevent food from getting through. Should there be a lapse of 3-4 weeks between the time of the diagnosis and the operation, the surgeon would normally find so-called stipple-shaped metastases on the peritoneum and, if a tomogram of the liver was ordered shortly before or after the operation, would find the solitary round focus right dorsally on the liver.

Such a condition is normally declared inoperable, incurable and a case to be given up, whereas we can systematically and biologically conclude that the patient has suffered secondary conflicts iatrogenically because of the diagnosis and subsequent interventions. More than likely, the surgeon, because of his lack of understanding the interrelationships, will attempt to cut as much as possible of this round focus and scrape off what he can of the 'peritoneal metastases'. The patient, if he now believes he has been cleared of the malignancy, manifests an ascites as a sign of his healing, and will then be regarded by the surgeon and the oncologist as having entered the beginning of his final stage, since the interconnection of events has not been understood.

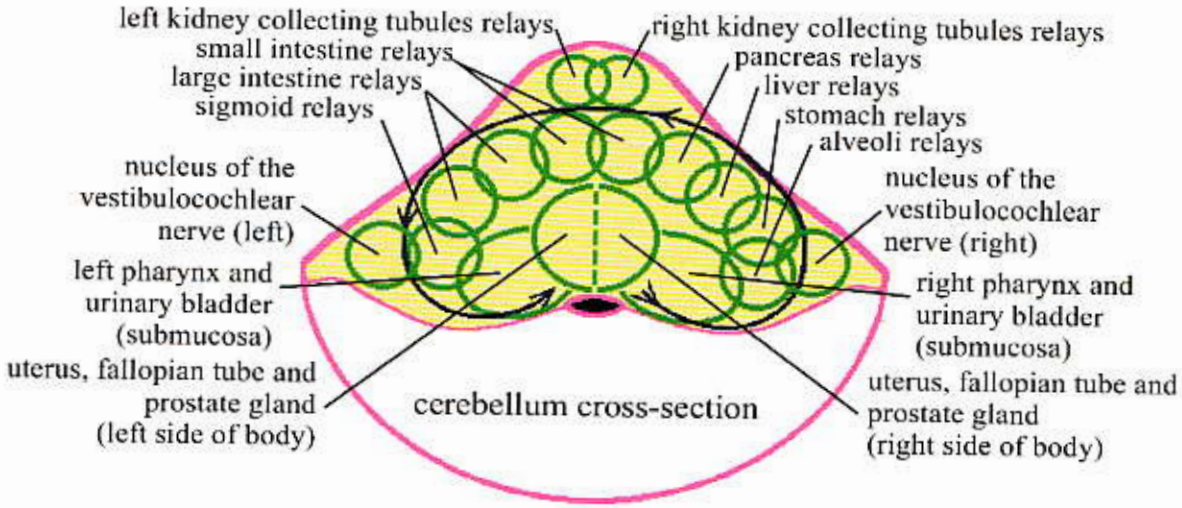
In the NEW MEDICINE, this patient would be treated more carefully from the psychological, clinical and cerebral points of view. The same diagnosis would be explained tactfully and with great care. The patient would be made to understand that the condition was not severe. Since the conflict was not solved, a solution would be sought with the patient, and then a wait as the sour-resistant rods assisted towards a spontaneous remission of the intestinal carcinoma. The patient would then not suffer either a liver or a peritoneal carcinoma. The prognosis would be quite good, even though there are a small number of cases with a danger of bowel/intestinal obstruction and where obviously a prophylactic operation would be required. But the results would almost always be positive, since there would be no collateral complications.

This is the sequence of events animals go through; they almost never suffer metastases, a fact that has failed to inspire our physicians or oncologists to do some thinking. If treated thus, the patient is normally very co-operative. He experiences night-sweats (intestinal tuberculosis), pays attention to getting sufficient protein to counteract the protein loss, and learns how to deal with this kind of conflict for the future and how to treat it differently from the very beginning. Needless to say, the majority of surgical interventions would not be required.

9.1 Comments and explanations of the brain stem controlled conflicts and tumors (yellow section, Endoderm)

The archaic, oldest conflicts of our organism always involve the 'morsel', the 'hearing-morsel' (information morsel), the 'air-morsel' (respiratory morsel), the 'nutritive-morsel', the digestion of the morsel, the elimination of the morsel, the retention of the water-morsel in fugitive or existential conflict, when the 'fish' is thrown on land. When these ancient conflicts were programmed into our brain stems, our forefathers were ring-formed beings, like a closed round pipe with one opening for both intake and elimination. Peristalsis, also controlled by the brain stem—mid-brain, was the traffic control (a one-way street).
We find this ring-form in the brain stem again, since this is where all the organs controlled by the brain stem have their relays. In the case of a DHS leading to an HH, they show a ring-formed configuration:

schematic CT-section of the brain-stem



9.2 Comments and explanations on the biological conflicts of the brain stem

Conflict of not receiving an important piece of information	Adeno-carcinoma of the middle ear. The organism does not create a knot-like tumor, but multiplies cylinder cells along a flat surface in order to be able to get the important information in the future. Neurinoma of the acusticus, Biological meaning: CA-phase. PCL-phase: otitis media.
Conflict of inability to swallow the morsel	Adeno-carcinoma of the gums. After the DHS, the organism develops highly specialized, digestive juice-producing adeno-carcinoma cells to break up the morsel that is 'too large', since not being able to incorporate the morsel can mean life or death. Biological meaning: CA-phase. PCL-phase, caseination through fungi or tbc, to destroy the superfluous special cells.

Archaic fear-of-death conflict of inability to get air (the air/breath is the morsel)	Adeno-carcinoma of the alveoli of the lungs. After the DHS, the organism generates more special alveolar cells to improve the gas exchange in the alveoli. If there are large round foci in the lungs, this means that the fear of death conflict has lasted too long. Psychologically, the organism has produced too much 'good stuff'. Biological meaning: CA-phase. PCL-phase: cascination with myco-bacteria, lung tbc.
Conflict of inability to digest the morsel that is too large, conflict of indigestible anger	Adeno carcinoma of the small or of the large intestine. After the DHS, the organism multiplies the villous cells of the intestine to increase digestive juice production, to break-up/digest the morsel, make it smaller, so that it can pass through. This is followed by the conflict-resolution, the newly grown but now unnecessary cells we call a tumor are now cascinated and eliminated via night-sweats and sub-febrile temperature. We used to call this intestinal tuberculosis and we still do, but we did not understand that this was a healing phase following an intestinal carcinoma. Biological meaning: CA-phase. PCL-phase caseination through myco-bacteria and tbc. intestinal tbc.

10 The Diseases of the Middle Germ Layer (Mesoderm)

The organs governed by the mesoderm have been divided into two large groups - keeping in mind that everything has been precisely documented from the point of view of evolutionary history:

One group belongs to the old brain, the organs directed by the cerebellar relays - the corium-skin, pericardium, pleura and peritoneum - and the group directed by the cerebral medulla, which belongs to the cerebrum.

We know from the ontogenetic system of tumors and cancer-equivalent diseases that the organs directed by the old brain cause cell multiplication in the conflict active phase, whereas those directed by the cerebrum cause cell reduction, necroses, ulcers, holes and equivalents during the conflict active phase.

The glia cells found in the brain and in the nervous substance of the Schwann sheaths can have cell multiplication in the conflict active phase (neurofibromas) as well as in the healing phase related to the repair of the HH's in the brain. With respect to the ontogenetically conditioned system of microbes, the bacteria that belong to the mesodermal layer perform in the mesodermal organ realm by causing cell reduction and helping to destroy tumors. At the same time, they help organs directed by the cerebral medulla to decompose tissue in osteomyelitis, and also help to build up bone.

According to my information, an open bacterial fracture heals faster than a closed one. Surgeons operating on accident victims are now opening bones intentionally through pinning.

The mesodermal, old brain directed organs - like the corium, pericardium, pleura and peritoneum - in principle behave in a similar way to the organs of the inner germ-layer except that tumors are partially bulboid, as seen in the peritoneum where a patient was kicked in the stomach and experienced the biological conflict as an attack against the abdomen. On the other hand, if a patient had suffered a general attack against the stomach, the tumors would have grown on a flat plane.

It is important to understand that all cerebellar-controlled tumors create fluid in the healing-phase, either during tubercular decomposition or without tuberculosis and therefore without decomposition - the ascites. This provides a medium for the intestine's protection, for it needs to remain buoyant and swimming, and prevents fusing in the PCL-phase. At the pericardium, we call it pericardial effusion; at the pleura, we call it pleural effusion; at the peritoneum, we call it ascites. With skin tuberculosis, there is a kind of water pillow under the skin, i.e. the tuberculotic exudate of the corium cells.

The mesodermal organs directed by the medulla of the brain need special attention. In particular, the healing phase has been misdiagnosed; even when it has been correctly identified, it can cause difficulties.

I recently called three university hospitals and found no cases of rheumatoid arthritis. I asked myself if there is a difference between acute joint rheumatism of the knee and an osteosarcoma of the knee. The following are the facts: patients who had previously been diagnosed with acute joint rheumatism of the knee are now in oncology and being treated for osteosarcoma. Mortality in cases of acute joint rheumatism was practically unknown, whereas mortality for osteosarcoma of the knee is now extremely high. The fact that they are both one and the same has not been understood until now because we did not know that the difference between a fracture and a biological-conflict causes osteolysis of the bone in the healing phase. Given the laws of physics, an osteolysis in the vicinity of the knee in the healing phase - caused by a self-devaluation conflict (in one's ability to engage in sports,

for instance) - causes an edema in the direction of least resistance, the direction of the knee joint. It is easier to diffuse the edema through the knee's cartilage than to stretch the hard periost. Through defective testing, we failed to see the osteolyses near the joints. We therefore missed the conflict-active phase and consequently misunderstood the healing phase as a disease in itself, calling it acute joint rheumatism.

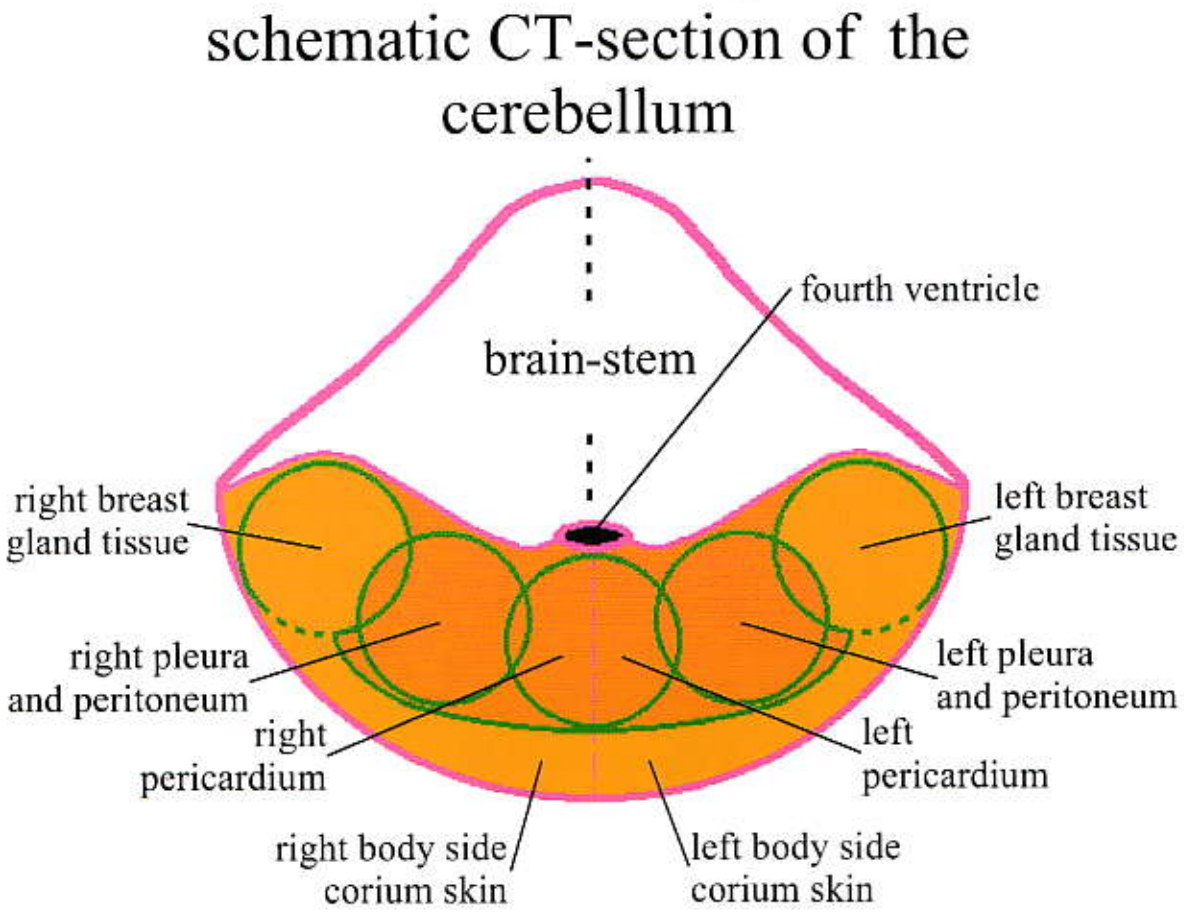
The mechanism with bone fractures for us humans is different. For an animal, bone fracture almost always leads to secondary osteolysis because its ability to run is impeded; if it is an animal of prey, it will face certain death; if it is a predator, it will probably also die because it can no longer hunt. For an animal, therefore, a broken leg is a serious matter of life and death. For us, on the other hand, a fracture is immediately clamped together and immobilized by a cast or some other method, and we are confident that everything will be back to normal in a few weeks.

The difference between osteolysis caused by a biological self-devaluation conflict and a fracture without a conflict or of a short duration, is that if there is healing after the osteolysis, there will be marked swelling of the bone, and periosteal lifting or separation. The fracture presents a callus formation without significant edema. It seems that the biological purpose in cases of self-devaluation conflicts lies in the healing-phase, when the bone becomes more calciferous and stronger than it was. During the conflict-active phase the patient only has a limited time to resolve his conflict or, gruesome as it may sound, he will become 'food for the lions'.

The same biological purpose applies to the remaining, cerebral medulla controlled diseases such as the lymph nodes, renal parenchyma, interstitial ovarian and testicular tissues, etc. Evidently, their main reason lies in the healing-phase. With the kidney, the indurated renal cyst eventually produces urine; this repairs the kidney for better urine production than it had before the disease. We have already mentioned this mechanism. Some urologists of the old medicine confirmed this fact after testing some of my conclusions. As a result, renal cysts are now operated on far less frequently than before. The same goes for ovarian and interstitial ovarian necrosis (with attached ovarian or testicular cysts). The indurated interstitial ovarian cyst eventually produces so much estrogen that a woman looks ten to twenty years younger. It does the same, conversely, for a man. His enlarged testicle produces so much more testosterone that he becomes more 'masculine' than before.

Once again I must stress that this new perspective is not my discovery; it accords completely with evolutionary history and with known facts. These facts must now be re-evaluated. A professor of histopathology in Southern Germany once told me that, with a microscope, it is frankly impossible to see if the callus cells derive from a fracture, an osteosarcoma or from acute joint rheumatism. He normally appends the designation 'malignant' or 'benign' after examining an x-ray. We may have over-estimated our histopathologists. I can think of a number of cases of histological findings that came back revised once they had been re-analyzed.

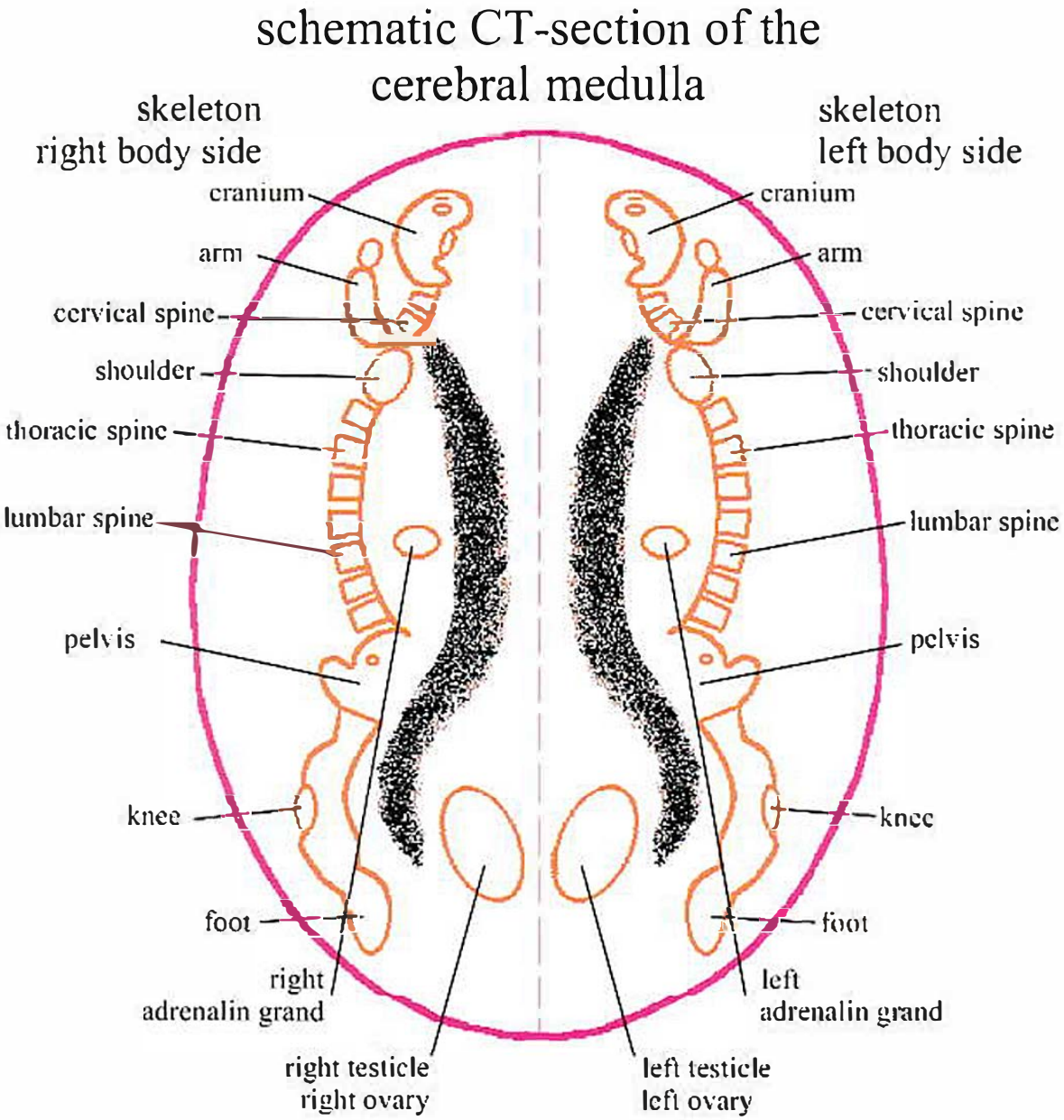
10.1 Comments and explanation of the conflicts and tumors of the organs controlled by the mesodermal cerebellar organs



Conflict of feeling attacked, injured or disabled. For example as one goes out the door the other aggressively calls out: „You pig!" Patient: „That hit me between the shoulder blades like an arrow".	The organism makes a melanoma or mesothelioma, in this case (adenoid-carcinoma, mitoses in the conflict-active phase) to strengthen and protect itself against further such attacks from the 'arrow'. It is an archaic defence from an evolutionary point of view. Our ancestors only had the corium skin. Biological meaning: CA-phase. PCL-phase: caseation with the aid of t.b. bacteria.
Aggression conflict against the integrity of the viscera. For instance, a male employer kicks a female employee in the stomach.	A growth in the CA-phase, a knotty mesothelioma invaginating from the peritoneum inside the abdomen at the exact location of the kick. Biological meaning: CA-phase. PCL-phase: ascites.
Example: the surgeon: „We must operate on your lung tomorrow" pointing to the right side of the rib cage and the patient imagines it being cut open, even though the tumor is on the left side.	The organism tries to protect itself by creating an internal reinforcement of the pleura = mesothelioma. In this case, the mesothelioma is on the right pleura. Biological meaning: CA-phase. PCL-phase:

	pleural effusion.
Example: an intern: „Your ECG is odd, something's wrong with your heart." The patient suffers a DHS with a mental attack against his heart. He imagines a bypass operation (something that happened to his neighbour).	The organism develops a mesothelioma as an attack defence in the CA-phase, pericardial mesothelioma. Biological meaning: CA-phase. PCL-phase: pericardial effusion, pericardial tamponade = heart insufficiency. Frequent cause for another DHS. (Pericardial track)

10.2 Comments and explanation of the conflicts and tumors of the mesodermal cerebral medulla directed organs



Self-devaluation conflict (SDC) a) generalized SDC infantile or senile b) specialized SDC i.e., mother-child SDC („I've been a bad mother") or a physical performance conflict	Bone osteolysis corresponding to definite locations of the skeletal system (c.f., chart) together with anaemia in a mother-child SDC: Osteolysis of the head of the left humerus for a right-handed woman. Physical performance SDC: Osteolysis near the knee joint, in the PCL-phase, knee joint effusion: the PCL-phase involves leukaemia. Biological meaning: PCL-phase; the periosteal pain of the healing osteosarcoma in the affected part of the skeleton accompanies not only recalcification, but also makes it stronger than before.
Water-or fluid conflict	Necrosis of the renal parenchyma, PCL-phase: kidney cyst. Biological meaning: PCL-phase, since the kidney cyst indurates and produces urine, the kidney itself works more efficiently than before.
A profound loss or an ugly semi-genital conflict (for example from a quarrel with a masculine figure) in the case of a woman	Ovarial-necrosis. PCL-phase ovarian cysts. Biological meaning: PCL-phase, the growing cysts become indurated, become a part of the ovaries and increase production of female hormones, especially estrogen. As a result, the woman looks much younger and can better deal with the conflict or even remove the cause; in the loss of a child, the woman can become pregnant more easily.
Profound loss-conflict in the male	Testicular necrosis. PCL-phase-testicular cysts, augmentation of the interstitial hormone producing testicular tissue. Biological meaning: PCL-phase because there is increased testosterone production and thereby greater 'masculinity'.
Conflict of having run in the wrong direction, having ended up on the wrong track	Necrosis of the adrenal cortex. Biological meaning: an exception both in the CA-phase and the PCL-phase: the necrosis reduces the production of cortisone and, in spite of the sympathicotonia, stops the running in the wrong direction. PCL-phase, as a result of the multiplication in the filling out of the necrosis and the simultaneous increase in volume of the adrenal cortex, there is significant cortisone production, and therefore an ability to run faster (for example, after the herd) and in the right direction.
Bleeding and injury conflict. The concept of bleeding and injury is to be understood purely biologically. This conflict is highly significant in the wild since it always decides between life and death. A bleeding and injury conflict means the individual is injured, probably seriously. It is a biological conflict of the breakdown of self-confidence.	Spleen necrosis. CA-phase: allows more thrombocytes to leave the blood circulation to be stored in the spleen, thereby reducing the chance of thrombosis in the blood ducts. Thrombopenia is therefore a very meaningful emergency measure of nature. The passing necrosis of the spleen allows increased space for thrombocyte storage in the spleen. PCL-phase: splenomegaly; it remains and therefore guarantees that if there is a bleeding-injury conflict again, there will be increased space

The damaged animal, still capable of flight, does not wait until the continued loss of blood makes any further defence impossible, but leaves the battleground quickly. This seems to be the psychic-biological meaning of the conflict. For us, hearing that we have a 'blood-cancer' could activate the bleeding-injury-conflict. It would be reactivated if we received blood transfusions over a period of time, relapsing again and again with each new blood-analysis.

in the spleen for thrombocytes. The spleen necrosis in the CA-phase and the splenomegaly in the PCL-phase have a biological meaning. The bleeding and injury conflict is possibly the only, or one of the few, conflicts where the organism counts on a relapse at the outset (generic for the lymph-nodes, given the spleen is just a special lymph-node). The specific biological meaning presumably is prevention in the case of a renewed bleeding and injury conflict.

11 The Diseases of the Outer Germ Layer (Ectoderm)

There is a certain homogeny in the diseases (special programs of nature) of the organs that belong to the outer germ layer which are controlled by the cerebral cortex. Strictly speaking, they should be divided into cancer and cancer-equivalent diseases, because the word cancer no longer really applies.

As with the mesodermal organs controlled by the cerebral medulla which make holes, necroses, osteolyses, lymph-node necroses, ovarial-necroses, and kidney necroses in the conflict-active phase, all squamous epithelia and mucus membranes develop ulcers in the conflict-active phase, and tissue loss. In conflict resolution, the lost tissue and the ulcers are rebuilt with new cells, which occurs under acute swelling. We did not know this in the past and thought that this ulcer replenishment by new cells was possibly a highly malignant tumor.

Besides this, we find another group of organs that we call cancer-equivalent diseases. These organs suffer only a functional loss or impairment during the conflict-active phase, i.e., hypoglycemia or diabetes, with a disturbance of the beta-or alpha-islet cells.

With these organs we see neither cellular increase nor decrease, 'only' the functional loss. However, something must be happening in the case of insulinoma, for it swells somewhat in the healing phase, yet there is no cell multiplication in the organ.

There are also some difficulties in definition when we speak of cancer-equivalent in the case of a fear-from-behind-conflict, with its HH in the visual cortex, because the neurologists tell us that the little rods and cones of the retina are part of the brain. What is certain, however, is that in every case, the *five* laws of the NEW MEDICINE are fulfilled on the psychic and cerebral level.

For the other kind of fear-from-behind which concerns the para-median portion of the visual cortex - the fear of robbers who threaten from behind - we see a clouding of the vitreous humor in the conflict-active phase that clears up in the healing phase.

In the case of the lens, which has nothing to do with the visual cortex but is conflictually related to a separation problem (when one loses someone from the field of vision), we see (c.f. chart) a necrosis in the conflict active phase. This allows the affected person to have better distance vision. In the healing phase, the lens clouds over temporarily while refilling itself. We call this a cataract. If this conflict happens only once, then the lens clears up; if it occurs again and again, the cloudiness increases.

We have specific definitional difficulties in the case of motor conflicts, the same as the vitreous humor, because motor conflicts on the one hand only show up as functional impairment, specifically as a motor paralysis. Aside from that, we notice that the affected organ, the muscle that belongs to the middle germ layer, shows so-called muscle loss or muscle atrophy.

Theoretically this could have two causes:

The muscle atrophies because it is no longer innervated. This is how we imagined it up until now. It is also possible that this is an encroachment process, which, as it concerns the outer germ layer, is a cancer-equivalent, thus resulting in functional impairment. But, at the same time, the muscle belongs to the middle germ layer and is part of the cerebral medulla-directed type which makes necrosis during the conflict active phase, meaning: the muscle fibres are destroyed, which we would still call muscular atrophy.

We also see this encroaching process with the female breast, where the ductal carcinomas of the milk-ducts strongly affect the mammary glands of the right and left cerebellar-directed breast. This means that mother-child breast and woman-partner breast

are always specific for one breast in the case of separation, quarrel or worry, but they show an exception in that they also react strongly in cerebral conflict sequence. This is why we can see the female breast as a linked system between cerebellum and cerebrum and that it is always strictly conflict related, not necessarily tied to the usual conflict ordering relationship. Thus, the left breast for the right-handed woman is affected: be it a worry or a quarrel with a child, as well as a separation conflict from it. That is why we are not surprised to find the encroaching process between cortical motor paralysis, which is ascribed to the outer germ layer, and the so-called muscular atrophy, classed with the middle germ-layer, directed by the cerebral medulla. This coupling, which should be called a complex event, was the cause for the incorrect diagnosis of 'multiple sclerosis', with foci frequently affecting muscle groups, as well as the related skeletal parts, mistakenly seen as the cause of motor or sensory paralysis.

It is obvious that the oldest parts of the brain naturally contain the most archaic conflicts and conflict-contents. As we move higher in phylogenetic evolution, our brains develop more complicated programs.

The cortical programs of our cerebrum are the most complex. The NEW MEDICINE, with its three levels of psyche, brain and organ, is structured virtually parallel with evolutionary logic:

From the archaically oldest programs of our brain-stem to the somewhat more complicated conflict contents of the cerebellum, to considerably more complex conflict contents of the cerebral medulla on to the most complex cortical conflict contents directed by the cerebral cortex. We think and feel with all parts of our brain, but these areas are differentiated by their reaction to the conflict-contents.

11.1 The conflicts of the outer germ-layer (ectoderm) and the biological meaning of these special programs of Nature

It would be inappropriate to recapitulate the whole chart once again. Instead, I will give specific examples of the earlier biological meaning of these so-called diseases; some of these meanings still apply today. Our cortical conflicts begin with the 16th/17th day of our embryonal ontogenesis, with the so-called three germ layer embryonic disk. It all began millions of years ago in the phylogenesis, when the addition of the cerebrum started a new era in our evolution.

From an evolutionary point of view, as far as the biological special programs of nature are concerned, we see an absolutely breathtaking development:

1. Conflicts and organ modifications of the endoderm controlled by the old brain and of the mesoderm controlled by the cerebellum. Biological meaning unequivocally in the conflict active phase. In the PCL-phase the now unnecessary tumor is removed in a significant manner by microbes.
2. Cerebral medulla conflicts and organ transformations of the mesodermal organs controlled by the medulla of the cerebrum. Biological meaning unequivocally in the PCL-phase, but with the lymph-node organs, both phases of disease have their special meaning.
3. Cerebral cortex directed conflicts and organ modifications of the ectoderm. The biological meaning here is the same as with the old brain directed organs, unequivocally in the CA-phase; however, this is accomplished by the opposite action from that of the old brain-directed organs, which show mitoses and cell multiplication. In this case, there are necroses or ulcers. Here too, it is necessary to recognize the

biological meaning of the biological special programs. Of course, there are programs in which both phases show a special biological meaning, for instance, in the separation conflict.

The following are some examples:

11.1.1 The biological territorial conflict

This concept signifies that the individual has lost his functioning environment. For example the stag has lost his forest, the wolf pack leader his prairie, man his own domain that includes his family, job, etc. The same kind of territorial conflict is possible if an essential component of the domain or territory leaves it, for instance, the wife, daughter, or lover.

CA-phase: A mobilizing of all strengths to restore the earlier status.

PCL-phase: A healing of the effects of this violent exertion. However, with cortical conflicts, the individual must pass the biological 'test' in this phase. This is relatively easy with the older conflicts, but for cortical conflicts the selection is pitiless. The highly complicated biological system around which these conflicts largely revolve apparently often functions only by a selection that brings consequences.

Biological meaning of the conflicts and organ transformations:

With these conflicts, there is more than one biological meaning. Mother Nature utilizes the 'process' of the biological conflict for several social functions at the same time. In one case this results in a resolution, whereas in another, the goal is the opposite; there must be no resolution. The action is simple in principle, but becomes very complicated in the reality of the individual case. It becomes increasingly complex when the phenomenon of schizophrenic constellation appears, which brings in yet another group-social meaning. It is moot to speak of therapy at this point, as it must ask itself: „Healing - whereof? Healing - why?"

Biological meaning:

1. Possible biological meaning:

CA-phase: coronary artery ulceration, specifically in the inner covering of the squamous epithelium, ensures an obviously larger than normal lumen of the coronary arteries during the CA-phase. In this way, a much larger amount of blood can be pumped per minute. The capability of the heart and of the whole organism significantly increases during the conflict active phase. The individual caught on the wrong foot with the DHS gets a second chance to defeat his rival. Patients with a territorial conflict who have angina pectoris are given tranquilizers during therapy because unawareness of the biological laws of the NEW MEDICINE leads to the incorrect assumption that stress has to be avoided. Without permission we reach into the biological meaning of these events and hollow out the conflict instead of help to resolve it. In any case, there is an immediate qualification, as we shall see in the next paragraph. Even in the name of nature, we should not resolve every territorial conflict!

2. Possibility:

Should the territorial conflict not be resolved within nine months, if it is of average conflict intensity, for human beings, conflict resolution means death from a heart infarct in the space of three to six weeks. The time periods for animals are different, but the principle is the same. However cruel it may sound, this second possibility has its biological meaning in the fact that the length of time in which one can retrieve one's territory is severely limited. If man or animal cannot manage this territorial recovery within the allotted time frame, the conflict resolution becomes useless, for he or it dies of it.

3. Possibility:

What happens if the conflict can never be resolved? Again, two possibilities:

a) With full conflict strength the individual attacks over and over again until it finally dies of exhaustion or is killed by its opponent; or

b) The individual accommodates itself to its conflict (i.e., becomes a second wolf). The conflict becomes downgraded, always active, but not serious. The individual has an ongoing but light angina pectoris, which he can live with. We call this a 'hanging conflict'. The individual can reach his full life span but he is, so to speak, permanently 'cerebrally castrated'. The Behavioural Researchers say that such a second wolf may not raise his tail, lift his leg to urinate or growl in the leader's presence. This second wolf has no more contact with she-wolves and may not mount them. In human terms, the second wolf is homosexual. This is Mother Nature's solution for building the pack's social structure. It is certain that such an individual cannot claim a leadership position, for it would immediately die of a heart infarction.

4. Possibility:

Schizophrenic constellation:

The individual is knocked out of competition by receiving a second active cortical conflict in the left cerebral hemisphere after an existing right temporal territorial conflict. No one pays attention to a madman, or, for that matter, to an animal; they, too, can have this schizophrenic constellation. Such a person or animal is 'potty', a clown, and the boss' court jester, right out of competition. Yet this has a specific Biological meaning

In the event of a catastrophe, such as if the leader of the pack is gored by a wild boar and there is no young (cerebrally uncastrated) wolf to take over, then the individual in schizophrenic constellation can take control of the pack, for a while or forever. Because of the schizophrenic constellation, almost no conflict mass has accumulated and he will not die from a heart infarction as would a 'second wolf'. The wolf in schizophrenic constellation therefore represents the security of the 'spare' for the pack, in the case of need. It would take too long in this brief summation of the NEW MEDICINE to explore all cortical conflicts from the point of view of their biological meaning.

Let us describe two other complex conflicts that allow us to study the so- called 'tracks'.

11.1.2 Hearing conflict, tinnitus

„I don't believe my ears; what I heard can't be true!"

For instance: A patient, driving from Brussels to Aachen in the autumn of 1992, fell asleep at the wheel at approximately 3 a.m. He may have travelled at 120 km an hour for half a kilometre with his eyes closed, and then dropped his speed to 100 km an hour. The different sound of the engine woke him up, as any experienced driver can understand. The patient received a DHS as he woke in absolute fright, with tinnitus in his left ear. This probably saved his life! To express it more precisely, the patient now had a double set of tracks. He always got tinnitus when he was tired and driving and the speed of the car fell below 120 km/hr., but he also got it upon awakening in the mornings. The biological meaning must be sought in the CA-phase, for it lies in the warning function: pay attention, don't fall asleep! Pay attention, the car is slowing down. Later, he would even have tinnitus when the car changed its engine noise through deceleration. Since the patient only had minor relapses, he suffered the occasional short apoplectiform deafness in the PCL-phase, which was not particularly difficult.

11.1.3 Motor conflict of not-being-able-to-escape

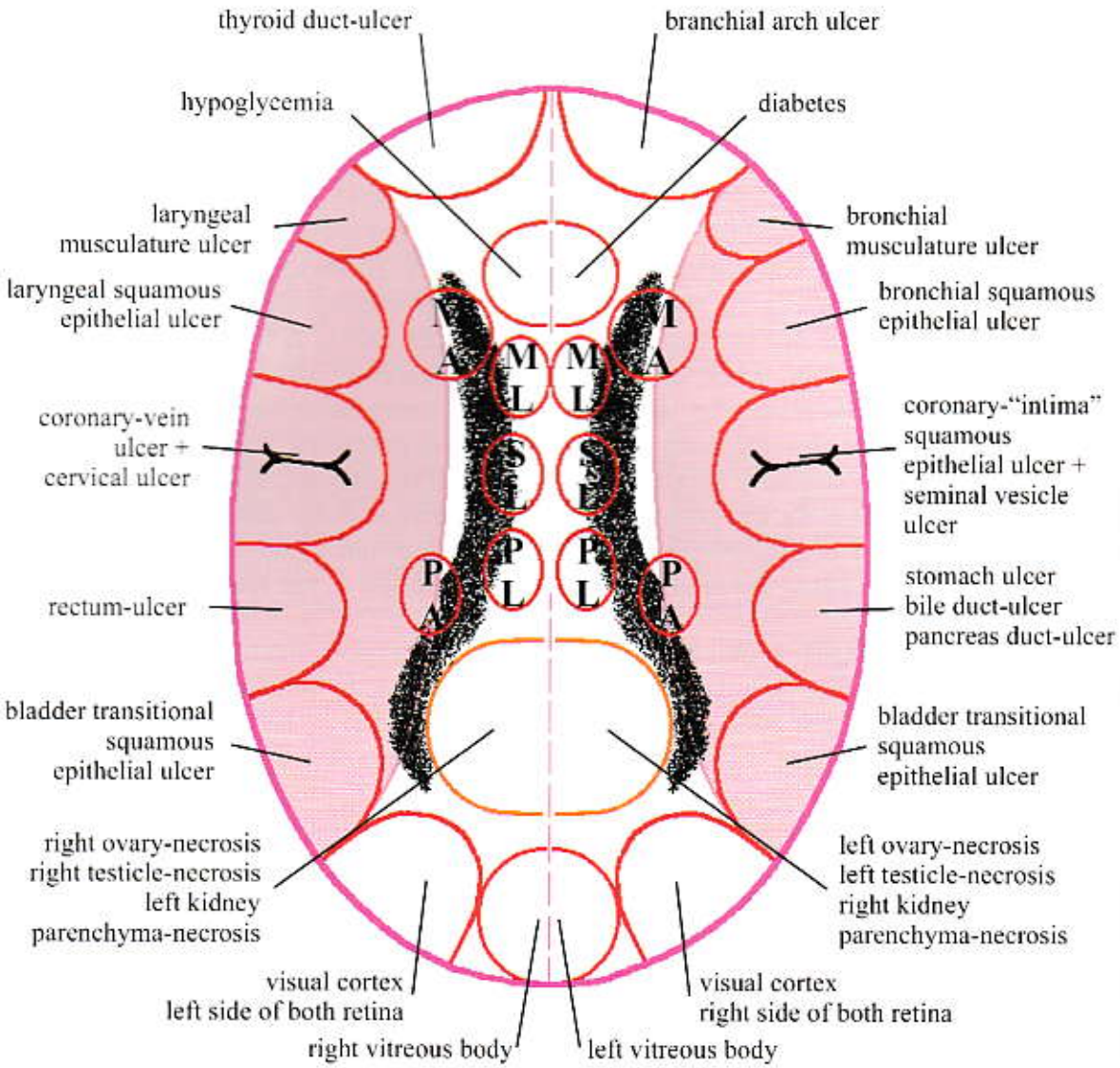
The biological conflict of not-being-able-to-escape has no recognizable psychological meaning, but does have a biological one: Many predators attack their prey only when it attempts to escape. A sick animal that doesn't run away is immediately suspect to the predator. For the prey this represents an opportunity: death-feigning-reflex!

An example:
Our boxer Basso was passionate about chasing little rabbits in the park. He has never caught one and probably does not really want to, but the fun is the chase itself. One day a small, sickly little rabbit hobbled along a path in the park. Basso sped away like a rocket. Our hearts stopped with fear. As Basso was about 5 metres away, the rabbit sat stock-still. Basso put the brakes on and stopped almost on top of the rabbit. It was frozen, so he just sniffed it and trotted away. When the dog was far enough away, the rabbit came out of its stupor and hobbled slowly on. The 'fake-death-reflex', many behaviour researchers inform us, is a fundamental reflex for many animals to survive predators. It is highly likely that these conflicts unfold similarly for all animals as well as for humans, but it is also probable that the biological sense for each race might have its own particular meaning. For instance, in the case of a herd of gnu, motor paralysis might point out to the lions the sacrificial victim, which would allow the herd a big distance advantage as the lion set upon the sick specimen.

Basically, every muscle group has a different natural function, and therefore, a paralysis with DHS must have a differentiable specific biological meaning in every case.

A further possibility of biological meaning could be sought in the PCL-phase: with the cerebral-medulla controlled organs (i.e., bones, ovaries, testicles, kidneys) we know that they enjoy an increase in function after completion of a healing phase. Bones, for example, are stronger than before the PCL-phase. In motor paralysis, muscles are atrophied, one could even say, necrotized. With our CT this is easy to see in our example where a real necrosis becomes clearly noticeable, as in M. Psoas (which is a muscle) that no one can explain. In the PCL-phase this could lead to a reactive hypertrophy of the muscle, resulting in a muscle stronger than before. All this must be systematically investigated in the future, with a broader basis. We will marvel at the many secrets Mother Nature still has in store for us. The biological meaning of a so-called disease, a special biological program, is incredibly important, if not perhaps the central pillar for understanding the NEW MEDICINE which itself is part of the base of scientific biology.

schematic CT-section of the cerebrum (cortex)



A = arm
L = leg
P = periosteum

M = motor cortex
S = sensory cortex

coloured section = sexual or territorial area

12 Tabular summary of THE NEW MEDICINE

Index and explanation of the medical terminology for the attached chart 'Psyche - Brain - Organ'

by Dr. Ryke Geerd Hamer, M.D.

Explanation of the abbreviations in the index:

y = yellow column
o = orange column
o r = orange column right
o l = orange column left
r r = red column right
r l = red column left

Example 1):
o.r.b.8 = orange column right, section b, No 8 = necrotizing Ca of the adrenal cortex

Example 2):
r.r.+ l.9.A.b = red, right and left columns, No 9, section A, part b

Achilles tendon rupture	o.r.+1.b.3
Acinar= referring to nodes	
Acne vulgaris = common acne	o.r.+ l.a.3
Acromegaly = excessive growth of the body extremities (acra) i.e., nose, chin, hands and feet	
Acoustic nerve = eighth cranial nerve	y.10
Acoustic relay = relay for hearing	r.r.+ l.b.5
Acoustic-neurinoma = neurinoma of the nucleus of the acoustic nerve	r.r.+ l.b.5
Adenoid = nodular	
Adenoidal vegetation posterior to the pharyngeal cavity	y.1
Adhesion = tissues sticking together	
Adrenal cortex cysts	o.r.b.8, l.b.7
Adrenal cortex necrosis	o.r.b.8, l.b.7
Adrenal medulla apoplexy	r.r.+ l.9.C.b
Adrenal medulla carcinoma	r.r.+ l.9.C.b
Adrenalin = hormone of the adrenal medulla	r.r.+ l.9.C.b
Albuminuria = appearance of albumen (water soluble protein) in the urine	o.r.+ l.C.1
Aldosterone = hormone of the adrenal cortex	o.r.b.8, l.b.7
Alimentary canal = oesophagus	r.r.+ l. 14
Alimentary canal, carcinoma of (lower third)	y.14
Alkaline phosphatase = enzyme	r.r.a.4.B
Allergic rhinitis	r.r.+ l. 11
Alopecia areata or totalis = partial or total hair loss	r.r.+ l.9.A.b
Alveolar = affecting the pulmonary alveoli	y.13.A
Alveolar Ca	y.13.A
Amelanotic = without melanin	o.r.+ l.a.1
Amelanotic melanoma = carcinoma of the dermis	o.r.+ l.a.1
Amelanotic melanoma tumors	o.r.+ l.a.3
Amelanotic tumors	o.r.+ l.a.2

Amenorrhea = period loss in women	r.l.a.3, 4.A
Anaemia = low red blood cell count	o.r.+ l.b.4
Anaemia (pseudo)	o.r.+ l.b.4
Anaesthesia = disruption of skin sensitivity	r.r.+ l.9.C.a
Angina pectoris = pains in the heart area with anxiety and constriction	r.r.+l.a.2
Anicteric hepatitis = liver-bile duct-inflammation, no yellow skin or sclera	r.r.a.4.B
Anosmia = loss of sense of smell	r.r.+ l.b.4
Anuria = absence of urine formation	r.r.+ l.a.6,8
Appendicitis	y.21
Appendix = ileus	y.21
Appendix = cecal appendage	y.21
Appendix obstruction	y.21
Appendix perforation	y.21
Appendix, Ca of the appendix	y.21
Aqueduct = connecting channel filled with cerebro-spinal fluid located between the 3rd and 4th ventricles	r.r.+ l.b.1
Aqueduct compression	r.r.+ l.b.1
Arm muscle atrophy	o.r.b.12, l.b.11
Arm muscle paralysis	r.r.+ l.b.3
Arrhythmia = irregularity of the heart beat	r.r.a.3
Arteriosclerosis = calcification of the arteries	o.r.b.9, l.b.8
Arteriosclerotic plaque = a layer of connective tissue and calcium deposits	o.r.b.9, l.b.8
Arterial wall necrosis	o.r.b.9, l.b.8
Arterial blood vessel necrosis	o.r.b.9 l.b.8
Artery	o.r.b.9, l.b.8
Ascites = abdominal dropsy	o.r.+ l.a.7
Asthma, laryngeal	r.l.a.2
Asthma	r.r.+ l.a.2
Asthma, bronchial	r.r.a.2
Atelectasis = total or partial alveolar blockage by occlusion of a bronchus, alveoli expand only partially or not at all	r.r.a.2
Atheroma	r.r.+ l.9.C.a
Atrophy = tissue and organ wasting	o.r.b.12, l.b.11
Atrophy of the muscles of the arm	o r b 12, l b 11
Autonomous nervous system = involuntary nervous system	r.r.+ l.9.C.b
Basedow's disease	y.7
Benign = non malignant	
Beta islet cells, cells of Langerhans	r.r.b.2
Bilirubin = the orange-yellow pigment of bile	r.r.a.4.B
Bladder, bleeding (cystorrhagia)	r.r.+ l.a.5
Bladder carcinoma, submucosal	y.29
Bladder catheter = tube used to extract urine from the bladder	r.r.+ l.a.8
Bladder inflammation = cystitis	y.29
Bladder pains	r.r.+ l.a.5
Bladder polyps	y.29
Bladder spasms	r.r.+ l.a.5

Bladder ulcerating carcinoma	r.r.+ l.a.5
Blepharitis = inflammation of the eyelids	r.r.+ l.9.A.c
Blood cells	o.r.+ l.b.4
Blood, chemical parameters, malfunction	r.r.+ l.b.1
Blood, sugar level, too high = hyperglycaemia	r.r.b.2
Blood, sugar level, too low = hypoglycaemia	r.l.b.2
Blood, high blood pressure = hypertension	o.r.+ l.c.1
Blood, transfusion	o.r.b.7
Blood vessels	r.r.+ l.a.3; o.r.b.9,10, l.b.8,9
Bones	
Bones, decalcification holes	o.r.+ l.b.4
Bone loss	o.r.+ l.b.4
Bones, pain	r.r.+ l.9.C.a; o.r.+ l.b.4
Bones, periosteal pain	r r + l b 8; o r + l b 4
Bones, spontaneous fractures	o.r.+ l.b.4 cancer o.r.+ l.b.4
Branchial arch, c.f. duct of pharyngeal arch	
Breast = mamma	o.r.+ l.a.4; r.r.+ l.9.B
Breast carcinoma	o.r.+ l.a.4; r.r.+ l.9.B
Breast, mastitis	o.r.+ l.a.4
Breast, nodes in the	o.r.+ l.a.4
Breast, pains in	r.r.+ l.9.B; o.r.+ l.a.4
Breast, swelling of (mastoncus)	r.r.+ l.9.B
Bronchi = bronchial branches	r.r.a.2
Bronchial asthma	r.r.a.2
Bronchial carcinoma	r.r.a.2
Bronchial haemorrhage = haematemesis	r.r.a.4.A
Bucal carcinoma, submucosal	y.12
Bucal mucosa ulcerative carcinoma	r.r + l.12.A
Bucal mucosa, haemorrhages	r.r.+ l.12.A
Bucal-mucosa inflammations	y.12
Ca = carcinoma	
Caecum = vermiform appendix	y.21
Caecum carcinoma	y.21
Caecum inflammation	y 21
Callus = re-growth of the bone tissue after breaking a leg, for example, where both ends are joined through calcification and new bone tissue grows in	
Caries = tooth cavities	r.r.+ l.10
Cartilage, loss of	o.r.+ l.b.2
Cartilage, necrosis	o.r.+ l.b.2
Cartilage, proliferation	o.r.+ l.b.2
Cataracts, gray	r.r.+ l.9.A.e
Catecholamine (primary)	r.r.+ l.9.b
Catecholamine (secondary)	r.r.+ l.9.C.b
Cavern = a hole resulting from caseation of cancerous tissue with liver, lung, pancreas, kidney and breast cancers.	
Cavern, liver = a hole resulting from caseation in liver	y.17

tuberculosis	
Cavern, lung- = a hole resulting from caseation in lung tuberculosis	y.13 A
Centralization = narrowing of the lumen of peripheral blood vessels	r.r.+ l.a 3
Cerebral coma, specified in	r.r.a.4.B
Cervical spine	o.r.+ l.b.4
Cervix	r. l.a.3
Cervix, ulcerating carcinoma	r. l.a.3
Chondro-sarcoma = new growth of cartilage tissue	o.r.+ l.b.2
Cirrhosis, atrophy, shrinkage of the kidney	o.r.+ l.c.1
Cold (catarrh), purulent	r.r.+ l.13
Collum-uteri-carcinoma = cervical cancer	r.l.a.3
Colon = the portion of the large intestine between the caecum and the rectum	y.22
Colon carcinoma	y.22
Conjunctiva = connective tissue of the eye	
Conjunctivitis = inflammation of the connective tissue of the eye	r.r.+ l.9.A.e
Connective tissue carcinoma	o.r.+ l.b.1
Connective tissue necrosis	o.r.+ l.b.1
Corium = dermis	
Corium carcinoma	o.r.+ l.a.1
Cornea, opacity, clouding	r.r.+ l.9.A.e
Cornea, ulceration	r.r.+ l.9.A.e
Coronal = referring to the heart	r.r.+ l.a.3
Coronary arteries = heart arteries	r.r.a.3
Coronary artery stenosis = narrowing of the coronary arteries	r.r.a.3
Coronary artery ulcerating carcinoma	r.r.a.3
Coronary vein ulceration	r.l.a.3
Corpus uteri = womb, uterus	y.26
Corpus uteri carcinoma	y.26
Corpus vitreum = vitreous humor of the eye	r.r.+ l.b.6
Cortex = cerebral cortex	
Cortisol = adrenal cortex hormone	o.r.b.8, l.b.7
Coughing	r.r.+ l.a.2
Cranial vault	o.r.+ l.b.4
Crohn, morbus	y.19, 20
Curvature = deformity	
Cushing syndrome = healing phase after necrosis of the adrenal cortex, i.e., a cyst of the adrenal cortex. The cyst produces more cortisol; therefore, an increase of hair growth	o.r.b.8, l.b.7
Cyst, cavern with liquid or viscous contents	
Cystitis = inflammation of the urinary bladder	y.29
Deafness, hearing of	r.r.+ l.b.5
Deafness, hearing, above all bad hearing	y.9,10, A +
Deafness, sensation of	r.r.+ l.b.7,9.A.a.+Ca
Death fright conflict	y.13.A
Death fright conflict, as symptom of the PCL-phase, listed under	r. r.+ l.a.3
Decidua = physiologic growth of the uterine mucosa under	y.29

(FSH) hormonal influence	
Dental, changed sensitivity, warm/cold, sweet/ sour	r.r.+ l.10
Dental, dentin, cancer,	o.r.+ l.b.5
Dental, dentin, caries	o.r.+ l.b.5
Dental, dentin, osteolysis	r.r.+ l.b.5
Dental, enamel	r.r.+ l.10.12.B
Dental, enamel, caries	r.r.+ l.10.12.B
Dental, enamel, necrosis	r.r.+ l.10
Depression	r.r.+ l.a.3; r.r.b.1
Dermatitis = inflammation of the skin	r.r.+ l.9..A.a
Dermis, carcinoma	o.r.+ l.a.1
Diabetes mellitus	r.r.b.2
Diastase = pancreatic juice enzyme	r.r.4.C
Diencephalon = midbrain	
Diencephalon, compression of the aqueduct	r.r.+ l.b.1
Diseases of the skin	r.r.+ l.9.A.a; o.r.+ l.a.1.2.3
Disturbed thoughts	r.r.+ l.9.A.a
Dopamine = hormone of the adrenal medulla	r.r.+ l.9. C.b
Ducts of the pharyngeal arch = rudimentary ducts, in evolution the organ used by fish for respiration	r.r. a.1
Ducts of the pharyngeal arch, squamous epithelium carcinoma (c.f. branchial arch)	r.r.a.1
Duodenum = superior portion of the small intestine	y.16; r.r.a.4.A
Duodenum carcinoma (without bulb)	y.16
Duodenum ulceration	r.r.a.4.A
Dyschondosis = cartilage disease with progressive deterioration	o.r.+ l.b.2
Dyspnea = respiratory distress	r.l.a.h3
Dystopic = congenital misplacement in organ location	y.24
Dystrophy = irregularity in normal growth	r.r.+ l.b.3
Ear drum	y.9 + 10
Eardrum, perforation	y.10
Ear, discharging	y.10
Ears, poor hearing	y.9,10; r.r.+ l.b.5
Ears, ringing = tinnitus	r.r.+ l.b.5
ECG = electrocardiogram = measurement of heart currents	r.r.a.3
ECG, disturbances	r.r.a.3
Eczema	r.r.+ l.9.A.a
Edema = strong tissue fluid deposits	
Effloresecence = a type of skin rash	r.r.+ l.b.3
Embolism = occlusion of a blood vessel through a plug	r.l.a.3
Endocardium = internal wall of the heart	o.r.+ l.c.4
Endocardium, necrosis	o.r.+ l.c.4
Endometrium = mucosa of the uterus	y.26
Epileptic attacks	r.r.+ l.b.3
Epileptic crisis, listed under	r.r.+ l.a.3
Epileptoid crisis, listed under	r.r + l.a.3,b.2 +3, r.a.4.A + B + C
Epiploon = omentum, great peritoneal fold	y.25

Epithelium = top layer of the skin and of the mucosae	
Epitheleal ulceration of the skin	r.r.+ l.9.A.a
Esophagus = top part of the alimentary canal	r.r.+ l.14; y.14
Esophagus, carcinoma (lower third)	y.14
Esophagus, stenosis	r r + l b 14
Esophagus, ulcerating carcinoma (top 2/3)	r.r.+ l.14
Esophagus, varices	y.14
Eustachian tubes carcinoma	y.9
Euthyreote = thyroid gland cyst	r.l.a.1
Euthyroid = normal function of the thyroid	r.l.a.1
Euthyroid struma	r.l.a.1
Exanthema = acute, temporary skin rash	r.r.+ l.9.A.a
Expiration = letting air out of the lungs	r.r.a.2
Expiration, gasping	r.r.a.2
Extrahepatic = outside the liver	r.r.a.4.B
Extrahepatic bile duct ulcerating carcinoma	r r a 4 B
Exudate(effusion)= fluid elimination from tissues	o.r.+ l.a.5+6
Eyeball	r.r.+ l.b.6
Eyes, tunnel vision	r.r.+ l.b.7
Eyes, dry	y.11; r.r.+ l.15
Eyes, inflammation, conjunctivitis	r.r.+ l.9.A.e
Eyes, lachrymating	r.r.+ l.15
Eyes, lens	r.r.+ l.9.A.c
Eyes, lids	r.r.+ l.9.A.c
Eyes, poor vision	r.r.+ l.b.6, 9.A.d+e
Eyes, suppurative, lachrymating	y.11
Facialis = nerve of the face	r.r.+ l.b.3
Facialis, paresis	r.r.+ l.b.3
Fallopian tube, carcinoma	y.28
Fallopian tube, obstruction	y.28
Fatigue stress	o.r.b.8, l.b.7
Fibrillation = irregular contraction of the cardiac muscle	r.l.a.3
Fila olfactoria = multiple small endings of the olfactory nerve	r.r.+ l.b.4
Fluor = discharge	y.26, 28; r.l.a.4.A
Fluor vaginalis = vaginal discharge, leucorrhea	r.l. a.4; y.26, 28
Foot	r.r + l.b.3; o.r.+ l.b4; r.b.12, l.b.11
Fovea centralis = 'central pit', retinal point with the greatest visual acuity	r.r. + l. b.6
Furunculosis = abscesses of the connective or adipose tissue	o.r.+ l.b.1
Gallbladder	r.r.a.4.B
Gallbladder, biliary stasis	r.r.a.4.B
Gallbladder, colics	r.r.a.4.B
Gamma gt = enzyme	r.r.a.4.B
Germ-line-cell teratoma	y.32
Glandula sublingualis = sublingual salivary gland	y.4; r.r.+ l.1.17
Glaucoma	r.r.+ l.b.7
Glioma = multiplication of glia (glial tissue = supporting tissue of the nervous system)	r.r.+ l.9.C.a

Glucagon = product released by the pancreas which raises the blood sugar level	r.l.b.2
Glucagon insufficiency	r.l.b.2
Goblet cells	y.13.B
Greater omentum carcinoma	y.25
Growth hormone	y.2
Hair growth	r.r.+ l.9.A.b
Hair-loss = alopecia	r.r.+ l.9.A.b
Hand	o.r.+ l.b.4, r.b.12, l.b.11; r.r.+ l.b.3
Hearing, conflict of	r.r.+ l.A.b.5
Hearing, failure	r.r.+ l.b.5
Hearing, loss	r.r.+ l.b.5
Hearing, poor	r.r.+ l.b.5, y.9 + 10
Hearing, poor	y.9; y.10; r.r.+ l.b.5
Hematemesis = vomiting blood	r.r.a.4.A
Hematocrit = percentual contents of formed blood corpuscles in relation to blood serum	o.r.+ l.b.4
Hematopoiesis = formation of red blood cells	o.r.+ l.b.4
Hemispheres = halves of the brain	
Haemorrhoids = vein expansion	y.24; r.l.a.4.B
Haemorrhoids, bleeding	r.l.a.4.B
Hepatitis = inflammation of the hepatic ducts	r.r.a.4.B
Hepatitis A and B	r.r.a.4.B
Hepatitis non A, non B	r.r.a.4.B
Hirsutism, development of male hairiness patterns in a woman,	o.r.b.8; l.b.7
Hodgkins morbus = swelling of the lymph-nodes in the healing phase	o.r.+ l.b.6
Hormonal disturbance, sexual	r.r.+ l.a.3
Hormonal derailment, total	r.r.+ l.b.1
Hydrocephalus internus = water on the brain	r.r.+ l.b.1
Hyperchondosis = cartilage proliferation	o.r.+ l.b.2
Hyperesthesia = over sensitivity	r.r.+ l.b.8
Hyperesthesia of the periosteal nerves	r.r.+ l.b.8
Hyperesthesia of the skin	r.r.+ l.9.A.a
Hyperglycaemia = a higher level of blood sugar	r.r.b.2
Hypermasculin	r.l.a.3
Hypersensitivity	r.r.+ l.b.8
Hypersexuality	r.l.a.3
Hyperthyroid = increased activity of the thyroid gland	y.7 + 8
Hypertension = high blood pressure	o.r.+ l.c.1
Hypertonia = increased muscle tone	
Hypertrophy = excessive growth	o.r.b.12, l.b.11
Hypoesthesia = diminished sensitivity	r.r.+ l.9.C.a
Hypoesthesia of the skin	r.r.+ l.9.C.a
Hypoglycaemia = glucose values are too low	r.l.b.2
Hypophyseal adenoma	y.2
Hypophyseal, anterior carcinoma	y.2
Hypophysis = pituitary gland	y.2

Hyposmia = loss of smell	r.r.+ l.b.4
Iatrogenic = caused by the physician	o.r.+ l.a.4
Icteric hepatitis = inflammation of the hepatic ducts with jaundice	r.r.a.4.B
Icterus = jaundice	r.r.a.4.B
Ileum = lower portion of the small intestine	y.19 + 20
Ileum carcinoma	y.20
Ileus = occlusion, mechanical	y.19, 20, 21, 22, 23; o.r.+ l.c.2
Ileus, appendix	y.21
Ileus, paralytic	o.r.+ l.c.2
Inner navel (omphalocoele) carcinoma	y.31
Innervation, nerve supply	
Insufficiency, lower than required function in an organ, listed under	o.r.+ l.a.5
Insulin	r.r.b.2
Interstitial = in between tissues	
Intestinal = pertaining to the gastro-intestinal tract	
Intestinal bleeding	y.19, 20, 22, 23
Intestinal colics	o.r.+ l.c.3
Intestinal musculature necrosis	o.r.+ l.c.3
Intestinal paralysis	o.r.+ l.c.3
Intestinal peristalsis = serial contractions of smooth muscle forces food through the digestive tract	o.r.+ l.c.3
Intima = inner wall of blood vessels	o.r.b.9, l.b.8
Intrabronchial = in the bronchial branches	r.r.a.2
Intrabronchial ulceration	r.r.a.2
Intrabronchial, carcinoma of the squamous epithelium	r.r.a.2
Intraductal mammary carcinoma = cancer in the milk ducts of the breast	r.r.+ l.9.B
Intrahepatic = in the liver	r.r.a.4.B
Intrahepatic, ulcerating carcinoma of the hepatic ducts	r.r.a.4.B
Jejunum = middle portion of the small intestine	y.19
Joint, rheumatism	o.r.+ l.b.4
Keloids = proliferation of scar tissue	o.r.+ l.b.1
Keratitis = inflammation of the cornea	r.r.= l.9.A.c
Kidneys, blockage	r.r.+ l.a.6
Kidneys, cavities (caverns)	y.30
Kidneys, colics	r.r + l.a.6 + 7
Kidneys, collecting tubules, carcinoma	y.30
Kidneys, cysts	o.r.l.c.1
Kidneys, pains	r.r.+ l.a.7
Kidneys, parenchymatous necrosis	o.r.+ l.c.1
Kidneys, renal calyx	y.30; r.r.+ l.a.7
Kidneys, renal calyx, enlarged	y.30
Kidneys, renal pelvis	r.r.+ l.a.6+7; y.30
Kidneys, spasms	r.r.+ l.a.7
Kidneys, stones (renal calculi)	r.r.+ l.a.6 + 7
Kidneys, tuberculosis of	y.30

Kidneys, tubules	y.30
Kidneys, ulcerative carcinoma	r.r.+ l.a.6 + 7
Knees	o.r.+ l.b.4
Lachrymal glands, ducts of, tumor	r.r.+ l. 15
Lachrymal glands, ducts of, carcinoma	y.11
Lachrymal glands, ducts of, ulcerating carcinoma	r. r.+ l.15
Lachrymal glands, swelling	y.11
Large intestine, carcinoma of	y.22
Laryngeal asthma	r.l.a.2
Laryngeal asthma	r.l.a.2
Laryngeal squamous epithelium carcinoma	r.l.a.2
Larynx	r.l.a.2
Lateral sclerosis	r.r.+ l.b.3
Leg muscles, atrophy of	o.r.b.12, l.b.11
Leg muscles, paralysis	r.r.+ l.b.3
Leg veins	o.r.b.10, l.b.9
Leukaemia = healing phase after bone cancer with a significantly increased count of leucocytes and their immature forms (blasts)	o.r.+ l.b.4
Liver = hepar	r.r.a.4.B; y.17
Liver carcinoma (solitary)	y.17
Liver caverns	y.17
Liver coma	r.r.a.4.B
Liver foci, round	y.17
Liver parenchyma	y.17
Liver spots	o.r.+ l.a.1
Liver tuberculosis	y.17
Liver, cirrhosis	r.r.a.4.B; y.17
Liver, values	r.r.a.4.A
Loss of smell, sense of	r.r. + l.b.4
Lumps in the breast	o.r. + l.a.4
Lung, caverns	y.13 A
Lung, embolism	r.l.a.3
Lung, embolism, acute right heart infarction	r.l.a.3
Lung, metastasis	y.13 A
Lung, mucoviscidosis = cystic fibrosis	y.13
Lung, pulmonary (lung) nodules	y.13 A
Lymph nodes, holes in	o.r.+ l.b.6
Lymph nodes, necrosis	o.r.+ l.b.6
Lymph nodes, swelling	o.r.+ l.b.6
Lymph vessels, necrosis	o.r.b.11, l.b.10
Lymph, drainage	o.r.b.11, l.b.10
Lymphoma = enlarged, swollen lymph-nodes	r.r.a.1
Lymph-vessels, proliferation	o.r.b.11, l.b.10
Mamma = breast	r.r.+ l.9.B; o.r.+ l.a.4
Mamma, carcinoma	o.r.+ l.a.4, r.r.+ l.9.B
Mamma, carcinoma, intraductal	r.r.+ l.9.B
Manic agitation occurs with different diseases, listed under	r.l.a.1
Mastoid tumor = wart-like evagination in the petrous bone (temporal bone portion containing the auditory canal)	y.10

Mediastinal thyroid gland cysts	r.l.a.1
Mediastinum = space between the lungs	r.l.a.1
Melanoma = tumor originating in the pigment cells	o.r.+ l.a.1
Menstruation = period	y.26; r.l.a.3 + 4 A
Menstrual haemorrhaging = period bleeding	y.26; r.a.3
Mesothelioma = tumor of the pericardium, pleura or peritoneum (adenoid)	o.r.+ l.a.5,6,7
Mesothelioma, pericardium	o.r + l.a.5
Mesothelioma, peritoneum	o.r.+ l.a.7
Mesothelioma, pleura	o.r.+ l.a.6
Metastasis = according to conventional medicine, secondary growths	o.r.+ l.a.5
Middle ear, carcinoma	y.10
Middle ear, inflammation	y.9 + 10
Milk ducts, occluded	r.r + l.9.B
Mitosis = indirect cell division	
Morbus Addison, (Addison's disease) = disease of the adrenal gland cortex	o.r.b.8, l.b.7
Morbus Crohn, (Crohn's disease) = inflammation of the intestinal mucosa together with mucosal suppuration	y.19 + 20
Morbus Parkinson, (Parkinson's disease)	r.r.+ l.b.3
Motor = regarding movement	
Motor MS	r.r.+ l.b.3
Motor paralysis of the arms, legs, hands, back, shoulders and face	r.r.+ l.b.3
MS = multiple sclerosis	o.r.b.12, l.b.11, r.r.+ l.b.3
MS, motor	r.r.+ l.b.3
Mucoviscidosis (cystic fibrosis)	y.3, 4, 11, 13
Mumps	r.r.+ l.16
Muscle, atrophy	o.r.b.12, l.b.11
Muscle, dystrophy	r.r.+ l.b.3
Muscle, hypertrophy	o.r.b.12, l.b.11
Muscle, recovery (restitution)	o.r.b.12, l.b.11
Musculature	o.r.+ l.c.2, r.b.12, l.b.11, r.r.+ l.b. 3
Mycosis = disease with fungal occurrence	y.1-32; o. r.+ l.a.1
Neck of the femur	o.r.+ l.b.1
Necrosis = localized death of tissue	
Necrosis of the arterial blood vessels	o.r.b.9, l.b.8
Necrosis of the walls of the arteries	o.r.b.9, l.b.8
Neuralgia = nerve pain	r.r.+ l.9.A.a
Neurinoma = proliferation of the connective tissue in the neural sheath	r.r.+ l.b.5
Neuroblastoma = adrenal cortex overgrowth	r.r.+ l.9. C.b
Neurodermatitis = desquamation of the skin in the conflict active phase, in longer duration there is a thickening and hardening of the skin	r.r.+ l.9.A.a
Neurofibroma - proliferation of the connective tissue in the	r.r.+ l.9.C

neural sheath, multiplication of glial cell	
Neuroganglia (sympathetic trunk) = nerve nodes of the involuntary nervous system	r.r.+ l.9.C.b
Non-Hodgkins lymphoma - centrocystic- centroblastic = growth of the squamous epithelium during the healing phase, after previous ulceration of the larynx	r.r.a.1
Non-Hodgkins lymphoma = all diseases of the lymphatic system not part of the Hodgkins' syndrome	r.r.a.1
Noradrenalin = hormone of the adrenal gland cortex	r.r.+ l.9.C.b
Nose colds	r.r.+l.11, r.r.+ l.13
Nose, mucosa, ulcerating carcinoma	r.r.+ l.11
Nose, nasopharynx, polyps	y.1
Nose, paranasal sinus, ulcerating carcinoma	r.r.+ l.13
Nosebleeds	r.r + l.11
Occlusion,	r.r.+ l.a.6 of the ureters r.r.+ l.a.6 of the urethra r.r.+ l.a.8
Oedema (edema) = significant accumulation of tissue fluids	
Omentum carcinoma	y.25
Ontogenesis = embryonic evolution	
Opacity of the lens	r.r.+ l.9.A.e
Ophthalmic (n) = the top branch of the trigeminal nerve, fifth cranial nerve	r.r.+ l.9.A.c
Osteolysis = loss of bone tissue	o.r.+ l.b.4
Osteosarcoma = excessive new growth of bone tissue	o.r.+ l.b.4
Otitis media	y.9, 10
Ovarian carcinoma	o.r.b.13, l.b.12
Ovarian cysts	o.r.b.13, l.b.12
Ovarian teratoma	y.32
Ovarian tube = fallopian tube	y.28
Ovarian tube carcinoma	y.28
Ovarian tube obstruction	y.28
Ovaries = egg producing gonad	y.32, o.r.b.13, l.b.12
Ovaries = gland where ovum produced	y.32; o.r.b.13, l.b.12
Ovaries, reduced in size	o.r.b.13, l.b.12
Palate carcinoma	y.5
Pancreas	y.18
Pancreas carcinoma	y.18
Pancreas, cavern - cavity	y.18
Pancreas, ducts, carcinoma of the squamous epithelium	r.r.4.C
Pancreatitis, swelling of the aquamous epithelium of the pancreatic ducts	r.r.4.C
Panmyclophthisis = reduced or no growth of the bone medulla, causing blood formation to stop	o.r.+ l.b.4
Paralysis	
Paralysis of the muscles of the arm	r.r.+ l.b.3
Paralysis, motor: legs, arms, hands, back, shoulders, and face	r.r.+ l.b.3
Paralytic ileum = consequence of paralysis of the intestinal musculature, leading to the inability of the intestine to impel or	o.r.+ l.c.2

excrete	
Paraplegia	r.r.+ l.b.3
Parenchyma, necrosis	o.r.+ l.c.1
Paranoia = delusion	r.r.+ l.b.6
Parathyroids, carcinoma, glandular (acinar) section	y.8
Parathyroids, nodes	y.8
Parenchyma = specific organ tissue	y.17; o.r.+ l.c.1
Paresis = partial paralysis	r.r.+ l.b.3
Parkinson, Morbus = hanging healing stage after a motor paralysis	r.r + l.b.3
Parotid gland	
Parotid gland	y.3; r.r.+ l.16
Parotid gland (Stensen's) duct, ulcerative carcinoma	r.r.+ l.16
Parotid gland, carcinoma	y.3
Perforation = rupture	
Pericardium = heart sac (a double walled sac enveloping the heart)	o.r.+ l.a.5
Pericardium carcinoma = heart sac carcinoma	o.r.+ l. a.5
Pericardium exudate, circular	o.r.+ l.a.5
Pericardium, valve alteration	o.r.+ l.c.4
Pericardium, carcinoma	o.r.+ l.a.5
Pericardium, fibrillation right	r.l.a.3
Pericardium, infarction	o.r.+ l.a.5; r.r. + l.a.3
Pericardium, infarction left	r.r.a.3
Pericardium, infarction right	r.l.a.3
Pericardium, insufficiency	o.r.+ l.a.5
Pericardium, keloid of the walls	o.r.+ l.c.4
Pericardium, mesothelioma	o.r.+ l.a.5
Pericardium, necrosis of the valves	o.r.+ l.c.4
Pericardium, necrosis of the walls	o.r.+ l.c.4
Pericardium, pain	r.r.a.3
Pericardium, performance	o.r.+ l.c.4
Pericardium, tamponade, plug	o.r.+ l.a.5
Periosteum = bone skin	r.r.+ l.a.9.C.a, b.8; o.r.+ l.b.4
Periosteum pain	o.r.+ l.b.4; r.r.+ l.b.8
Peripheral glioma	r.r.+ l.9.C.a
Periphery = located on the outside of the body	
Peritoneal = membrane lining the inner cavity of the abdomen	o.r.+ l.a.7
Peritoneum carcinoma	o r + l a 7
Peritoneal mesothelioma	o.r. + l.a.7
Persecution mania	r.r. + l.b.6
Phantom = imaginary thing not existing in reality	r.r.+ l.b.8
Phantom ulceration of the squamous epithelium	r.r.+ l.b.8
Pharyngeal tonsil carcinoma	y.6
Pharynx	y.1
Pheochromocytoma = ulceration of the adrenal medulla	r.r.+ l.9.C.b
Pimples	o.r.+ l.a.3
Pleura = membrane lining the inner cavity of the chest,	o.r.+ l.a.6

enveloping the lungs	
Pleural carcinoma	o.r.+ l.a.6
Pleural exudate	o.r.+ l.a.6
Pleura, mesothelioma	o.r.+ l.a.6
Polyps, bladder	y.29
Polyps, nose, pharynx	y.1
Polyps, vocal chords	r.l a 2
Portio = opening of the uterus	r.l.a.3
Portio, carcinoma	r.l.a.3
Prolactin, the hormone that stimulates milk production	y.2
Prostate(male)	y.27
Prostate, carcinoma	y.27
Pseudo anaemia	o.r.+ l.b.4
Pubic bone	o.r.+ l.b.4
Pylorus = stomach opening into the duodenum	r.r.a.4.A
Rectum = the last 12 cm of the intestine passing into the anus	r.l.a.4.B; y.24
Rectum carcinoma = sigmoid carcinoma	y.23
Rectum, carcinoma, submucosal dystopic, pseudo, upper rectum location	y.24
Rectum haemorrhage	r.l.a.4.B
Rectum, ulcerating carcinoma	r.l.a.4.B
Rectum, ulcerating carcinoma, pains	r.l.a.4.B
Rectum, ulcerating carcinoma, spasms	r.l.a.4.B
Respiratory problems	o.r.+ l.a.5,6; r.r.a.1;r.r.+ l.a.2; r.1.a.3
Restitution = recovery	
Retina	r.r.+ l.b.6
Retina = light sensitive innermost layer of the eye	r.r.+ l.b.6
Retinal detachment	r.r.+ l.b.6
Retrosternal = behind the sternum	r.l.a.1
Retrosternal thyroid cysts	r.1.a.1.
Rheumatism	r.r.+ l.b.8
Rheumatism, joint	o.r.+ l.b.4
Rhinitis = inflammation of the mucosa of the nose	r.r. + l.11 + 13
Rough skin	r.r.+ l.9.A.a
Runny nose = rhinitis	r.r.+ l.11+13
Rupture of the Achilles tendon:	o.r.+ l.b.3
Scar keloid	a.r.+ l.b
Schizophrenic constellation = patient has at least one active conflict in each of the two hemispheres of the brain	r.r.+ l.a.2, a 3, l.a.4.A
Sclera = outer layer of the eye	r.r.+ l.b.6
Scrotum = testicular bag (marsupium)	o.r.b.14,l.b.13
Scrotum, edema (swollen)	o.r.b.14, l.b.13
Seeing, farsightedness	r.r.+ l.b.6
Seminal vesicle, ulcerating carcinoma	r.l.a.3
Sensible paralysis = loss of sensitivity	r.r.+ l.b.8
Sensitivity, paralysis = loss of sensitivity	r.r.+ l.b.8
Sensory paralysis = lack of sensory awareness	r.r.+ l.9.A.a
Shortsightedness	r.r.+ l.b.6

Shoulder	o.r.+ l.b.4
Shoulder, musculature	r.r.+ l.b.3
Sigmoid carcinoma = carcinoma of the pelvic colon = colon cancer	y.23
Sigmoid colon = pelvic colon = lower portion of the large intestine	y.23
Sinus, paranasal	r.r.+ l. 13
Sinus, paranasal, ulcerating carcinoma	r.r.+ l.13
Skeleton	o.r.+ l.b.4
Skin sensitivity	r.r.+ l.9.A.a
Sleeplessness listed under:	r.r.+ l.b.1
Small intestine carcinoma, upper	y.19
Small intestine, lower	y.20
Smooth muscle, necrosis of the intestine	o.r + l.c.2
Solitary = single appearance	
Spasm = cramping	
Spleen, cancer of	o.r.b.7
Spleen, holes in	o.r.b.7
Spleen, necrosis	o.r.b.7
Splenomegaly = swelling of the spleen	o.r.b.7
Spontaneous fractures	o.r.+ l.b.4
Squamous epithelium = e.g. the epidermis is constructed of layers of squamous epithelium	
Stenosis = narrowing	
Stomach carcinoma, without the small curvature	y.15
Stomach, colics	r.r.a.4.A
Stomach, pains	r.r.a.4.A
Stomach, ulcerating carcinoma	r.r.a.4.A
Stomach, ulceration, bleeding	r.r.a.4.A
Stomatocase, ulcerative stomatitis = ulcerations in the mouth	y.12
Stool, black = melaena	r.r.a.4.A; y.19
Striated musculature, necrosis	o.r.b.12, l.b.11
Stroke	r.l.b.3
Struma = goitre	r.l.a.1
Struma, goitre, benign euthyroid	r.l.a.1
Struma, hard = hyperthyroid goitre	y.7 + 8
Sublingual gland	
Sublingual gland, carcinoma	y.4
Sublingual gland, ducts of, ulcerating carcinoma	r.r.+ l.17
Sublingual salivary gland, carcinoma	y.4
Sublingual salivary gland, ducts, ulcerating carcinoma	y.4; r.r.+ l.1.17
Submucous = under the mucosa	
Suicidal = wishing to kill oneself, especially in schizophrenic constellation	r.r.b.1
Swallowing = deglutition, spasms	r.r.+ l.14
Swallowing stenosis	r.r.+ l.14
Sympathetic tract = see neuroganglia	r.r.+ l.9.C.b
Tachycardia = abnormal increased working of the heart with palpitations	r.l.a.3

Tamponade = compression of the heart as the pericardium fills with liquid	o.r.+ l.a.5
Tears, eyes tearing	r.r.+ l.15.
Tears, purulent	y.11
Tears, viscosity	r.r.+ l. 15, y.11
Teeth, changed sensitivity, warm/cold, sweet/ sour	r.r.+ l.10
Teeth, dentin, cancer,	o.r.+ l.b.5
Teeth, dentin, caries	o.r.+ l.b.5
Teeth, dentin, osteolysis	r.r.+ l.b.5
Teeth, enamel	r.r. + l.10,12.B
Teeth, enamel, caries	r.r.+ l.10,12.B
Teeth, enamel, necrosis	r.r.+ l.10
Tendon necrosis	o.r.+ l.b.3
Teratoma, a tumor composed of different kinds of tissue , none of which usually occur at the site of the tumor, most common in the ovaries and testes	y.32
Testicular carcinoma	o.r.b.14; l.b.13
Testicular cysts	o.r.b.14; l.b.13
Testicular swelling	o.r.b.14; l.b.13
Testicular teratoma	y.32
Testes = testicles	y.32
Testes, teratoma	y.32
Thalamus = part of the midbrain with important centres and nuclei,	r.r.+ l.a.5
Thrombocytes = blood platelets; having an important role in coagulation	o.r.b.7
Thrombocytopenia = reduced blood platelet supply	o.r.b.7
Thrombophlebitis = inflammation of the wall of a vein with blood clot formation	o.r.b.10, l.b.9
Thrombus = blood clot	r.l.a.3
Thrombus, embolism = a clot causing an occlusion in the small blood vessels and capillaries	r.l.a.3, o.r.b.7
Thyroid carcinoma, acinar portion	y.7
Thyroid cysts	r.l.a.1
Thyroid nodes	y.7
Thyroid, cold nodes	r.l.a. 1
Thyroid, function, increased = hyperthyroid or thyrotoxicosis	y.7
Thyrotoxicosis = increased function of the thyroid gland	y.7
Tinnitus = ringing in the ears	r.r.+ l.b 5
Tongue	y.12; r.r. + l.12.A
Tongue, mucosa of, haemorrhage	y.12; r.r.+ l.12.A
Tongue, mucosa of, ulcerating carcinoma	r.r.+ l.12 A
Tonsillitis = inflammation of the tonsils	y.6
Tonsils,	y.6
Tonsils, abscess	y.6
Tonsils, carcinoma of	y.6
Tonsils, enlarged	y.6
Tonsils, hyperplasia = excessive growth of the tonsils	y.6
Tonsils, mycosis	y.6

Tonsils, purulent	y.6
Transverse lesion of the chord, with paraplegia	r.r. + l.b.3
Trigeminal neuralgia	r.r.+ l.9.A.a
Trigeminus = fifth cranial nerve	r.r.+ l.9.A.b.+ c
Tubal = concerning fallopian tubes	y.28
Tubal carcinoma	y.28
Tuberculosis = the healing phase of diseases directed by the old brain	
Tubules = collecting tubes of the kidneys	y.30
Ulceration = abscess or boil	
Umbilical carcinoma, internal	y.31
Umbilicus, carcinoma of the inner layer	y.31
Ureter	r.r.+ l.a.6
Ureter	y.27; r.r.+ l.a.5
Ureter, occlusion	r.r.+ l.a.6
Ureter, partial occlusion	y.27
Ureter, spasms	r.r.+ l.a.8
Ureter, total occlusion	r.r.+ l.8
Ureter, ulceration	r.r + l.a.6
Urethra,	y.27, r.r.+ l.a.8
Urethra, partial occlusion	y.27
Urethra, total occlusion	r.r.+ l.8
Urethra, ulcerating carcinoma	r.r.+ l.8
Urinary bladder	y 29; r.r.+ l.a.5
Urinary bladder, submucosal carcinoma	y.29
Urinary bladder, ulcerating carcinoma	r.r.+ l.a.5
Urine, problems voiding	y.27, r.r. + l.a.6 + 8
Urticaria = nettle rash	r.r.+ l.9.A
Uterus = womb	o.r.+ l.c.3; y.26
Uterus, mucosa, carcinoma	y.26
Uterus, musculature, necrosis	o.r.+ l.c.3
Uterus, myoma = growths of the smooth muscle cells	o. r. + l.c.3
Vagina	r.l.a.4.A
Vaginal haemorrhage	r.l.a.4.A.+ 3.B; y.26
Vagina, ulcerative carcinoma	r.l.a.4.A
Vagina, ulcerative carcinoma, pains	r.l.a.4.A
Vagina, ulcerative carcinoma, spasms	r.l.a.4.A
Vaginismus = painful vaginal spasms	r.l.a.4.A
Varicose veins	o.r.b.10, l.b.9
Varicosities	o.r.b.10, l.b.9; y.14
Vegetation (adenoids) of the posterior pharyngeal cavity	y.1
Vegetative = part of the nervous system	
Vegetative, massive impairment of	r.r.+ l.b.1
Veins	o.r.b.10, l.b.9, r.l.a.3
Venous vessel, necrosis of	o.r.b.10, l.b.9
Vermiform appendix, carcinoma = appendix carcinoma	y. 21
Vision, deterioration of	r.r.+ l.b.6
Visual acuity	
Visual acuity, loss of	r.r. + l.b.6

Vitiligo	r.r.+ l.9.A.f
Vitreous humour of the eye = corpus vitreum	r.r.+ l. b.7
Vocal chords	r.l.2
Vocal chords, altered	r.l.a.2
Vocal chords, polyps of	r.l.a.2
Vomit = emesis	r.r.a.4.A
Waterhouse-Friedrichsen syndrome = necrosis of the adrenal cortex	o.r.b.8, l.b. 7

13 The 'Hamerschen Herde' (HH)

Ever since the introduction of brain CT's, aggregations of glial tissue that are easy to colour with contrast media, have usually been misdiagnosed as brain tumors.

In 1982, a year after the discovery of the Iron Rule of Cancer, I found a Hamerschenherd (HH) of gigantic proportions in a prospective patient with a territorial conflict who had suffered a heart infarction and was in the epileptoid crisis. From that moment, I knew that these could not be brain tumors but a phenomenon that must be associated with the healing phase of a biological conflict.

Hamerschenherd is a term originating from my opponents who derogatorily named the structures I had found in the brain 'comical Hamer Foci'. I started to observe these HH's with meticulous care and soon recognized those that were apparently activated at the start of the healing phase.

Since I had discovered the law of the two phased-ness of disease, I knew that every developing healing phase has had a corresponding conflict-active phase.

Unfortunately for many patients, the repair of HH's in the healing phase occurs through an accumulation of connective tissue glia cells. This creates an increased rigidity of the (brain) tissue but (the patient) remains free of complication as long as another conflict does not take place in the same location.

However, enormous difficulties arise:

1. With respect to cancer - which I concentrated on at the time because I thought I had merely discovered the mechanisms of its origin - it was not common to have CT's of the brain done unless there were grounds to suspect a brain metastasis. It was difficult in particular cases to obtain a brain CT because its high cost could not be justified. One was really lucky if a series of CT's of the brain could be obtained.
2. I immediately began work on establishing a topography of HH's in the brain. This was difficult because what I saw in the brain could well be the result of an old and resolved process, unrelated to the patient's current conflict. I also didn't know whether or not the patient had any other undiagnosed carcinomas - a strong possibility with respect to processes connected to biological conflicts occurring in the present.
3. I found overlapping conflicts with similar conflict contents, which I know today to have covered several relays with one single HH. This means that the patient suffered one or more conflicts with various conflict aspects that had all impacted in the same second of the DHS, resulting in a large HH.

   At the same time there were patients who had several HH's in very different locations in the brain. However, these had one thing in common where the patient demonstrated all the symptoms of a resolved PCL phase.
4. There had to be formations in the brain that corresponded to all these HH's in the healing phase - formations that would identify conflicts in the active phase. Sometimes I saw circles that looked like target-rings, but radiologists smilingly rejected them as circular artifacts created by the equipment. I also saw semicircular structures and those limited by the lateral frame of the CT.
5. Co-operation from radiologists was practically non-existent. Some of them had radiation equipment and practised so-called radiation therapy. These former colleagues could not afford to consider that my results had any validity. The rest told me point-blank – and not many radiologists had CT equipment at the time - that they would stop getting work from clinics the moment they considered my theories. Orders for CT's were normally exclusively to look for a brain tumor or a brain metastasis.

6. Since I had no access to any CT equipment, I was unable to do any systematic research or repeat an investigation from a different angle. We only got what 'fell from the master's table', and that was not much. Patients were frequently not given copies of their CT's and the written findings were of no use.
7. However, I was familiar with the HH's, or what I thought to be HH's, that related to the healing phase. I postulated that they must already have existed in the conflict active phase. Radiologists who said they saw nothing would not accept this conclusion.
8. I saw many HH's but could not associate them with any cancer. These were the motoric, sensory and sensory-periosteal relays in the brain that did not cause cancer at the organ level but might signify a cancer equivalent, something I had not counted on. That is why I often found many more HH's than I was looking for and in the cases where a patient had only one conflict and no resolution, I could not find anything.

A patient often had a gigantic tumor but 'nothing' in the brain CT. Others might have a small tumor in the healing phase and a swollen HH in the brain. I could do nothing but follow the path of all scientists. Employing 99% perspiration and 1% inspiration, I compared all the available brain CT's and their corresponding or seemingly corresponding organ findings, with other brain CT's which had different organ findings.

Another difficulty in those early days was not distinguishing left and right-handedness. In hindsight, I know that I probably made mistakes when I didn't start from the organ. The correlation from brain to organ or from organ to brain is always unequivocal. It is in the correlation between psyche and brain or brain and psyche that left and right-handedness is important.

For example: a right-handed woman with an identity conflict in the healing phase will get hemorrhoids, as will a left-handed man with a territorial anger in the healing phase. If I see an HH on the left side of the cerebrum at a specific site on the temporal lobe, with edema, then the patient is always suffering from hemorrhoids - i.e. ulceration of the squamous epithelium of the rectum in the healing stage. In reverse, if the patient is suffering from rectal ulceration in the healing phase - i.e. hemorrhoids - then there is an HH at this position in the left temporal lobe in the healing phase.

Later on, having looked at hundreds and then thousands of brain CT's, I learned the difference between cancers and cancer equivalent diseases and learned to establish the true location - specifically the correlative topography - to the organ. I must also emphasize that there are many bodily functions - as, for example the sensitivity of the periosteum that covers the whole skeletal system - where the CT's only show a white spot on the map of the brain and on the map of the organs. This is because examination of the periosteum is difficult, if not impossible. There is nothing in the textbooks on the sensitivity of the periosteum.

13.1 The ring-formations in brain CT's, misinterpreted by radiologists for fifteen years

The controversy remained regarding the ring formations that exist but are only observable in approximately one per cent of patients. I have called these 'HH's in a target configuration', and they indicate a conflict active phase and must be understood as such. With the exception of a few very clear formations, the radiologists treated them as nothing but artifacts produced by the equipment, and disputed my identification.

For many years this phenomenon was simply ignored. I finally had a good idea, justifying my earlier extensive studies in physics. I presented myself to Mr. Feindor, head of the CT division of Siemens. After a pleasant discussion I asked him if we could both

establish the criteria for when something was an artifact and when it was not. Mr. Feindor, an engineer, had no problems in establishing the conditions under which it would be possible to fulfill or not to fulfill one or other case. This took place on the 18th of December 1989. On the 22nd of December, the final protocol was signed. There was real panic among neuro-radiologists. We felt it in the New Year when we planned a set of tests to be undertaken at Siemens. I asked Mr. Feindor to allow me the use of the equipment in Erlangen to run a series of tests for about four weeks. We would invite a group of neuro-radiologists and show them that the demonstrated cases could not be artifacts but factual findings.

The appointed date was postponed again and again until finally a Siemens' representative told me they were having the most incredible difficulties with the radiologists. Disapproval was undoubtedly being voiced.

In preparation for the conference, we carried out all the studies originally stipulated with Siemens, such as moving the CT-Scan patient 2 cm to the right from centre or to the left of centre to determine whether the target configuration would stay in the same place on the brain, which it actually did. We also tried to carry out distance control wherever possible by systematically checking with different equipment to determine which setting showed the target configuration.

A dependable criterion for a real finding was if the target configuration only appeared in a determined number of layers but not in others. These studies, which took a lot of time, effort and persuasion of the radiologists, led us to an amazing discovery: one of the radiologists indicated that they really must be artifacts, because he had also seen them on organs.

From that moment, I was intensely interested in target configurations on organs and began systematically to look for them. I found that target configurations that can be seen on the compact organs on which we can do CT's - the liver, the spleen, the parenchyma of the kidneys, bones, etc. – are only visible at the beginning. They eventually become visible again when the bone re-calcifies. So was revealed the astonishing fact that the brain and the organ often have target configurations in simultaneous correspondence and the target configuration on the organ has a specific development. The classical target configuration on the liver can only be seen at the start of a solitary liver carcinoma. The solitary liver carcinoma later gets dark on the CT and can no longer be identified as such. When natural healing occurs through tuberculosis, calcification-rings can be seen - particularly if the site has not become cavernous, i.e. if there is no hole in the liver - especially in cases where the liver carcinoma has stopped growing halfway and the natural tubercular healing has only had to thin down the solitary nodule.

13.2 The head-brain and the organ-brain

In considering the matter correctly, on one side is the well-known head-brain and on the other are the organ cells, all of which have a cell nucleus. The organ cells are connected to each other and to each cell nucleus, indicating a mini-brain networking with all the mini-brains of the body.

The sum total of these mini-brains can be regarded as a second brain, so that in a biological conflict, an area of the brain called the HH enters into correspondence with an area of the body. This was called cancer, cancer equivalent or organ change.

In the case of a sensory stimulus, information flows from the organ brain to the head brain. It is the reverse with a motor response where the information and commands flow from the head brain to the organ brain. However, we do not know exactly what takes place electro-physiologically at the cellular level either in the brain or on the organ or what takes

place in the overlapping areas or relays. On the other hand, this knowledge is not a prerequisite to our working with these distinct findings.

13.3 The Hamerscher Herd in the CA-phase and the PCL phase

At the moment of a DHS, the corresponding specific brain relay is marked with a target configuration. These are sharp circles that form around the centre of the relay and look like targets. 'Target-configuration' means the HH is in the conflict-active phase.

The location is not accidental and is the computer relay that the individual associates with the contents of the conflict in the moment of the DHS. At the very same second, the organ correlated to this HH is impacted with cancer. Amazingly, we can also establish this impact on the organ through a target configuration on the compact organs that can be scanned, such as the liver, the spleen, bones and kidneys, etc.

With the advancing conflict, the HH in the brain also progresses. The impacted area keeps growing in size or the area becomes more and more intensely altered. As the cancer advances, the tumor grows bigger through real cell mitosis (for the endoderm), or through larger necrosis (for the mesoderm) or more ulcerated and expanded through many small ulcers (for the ectoderm).

In my first pocket edition (1984) of *'Krebs - Krankheit der Seele, Kurzschluss im Gehirn...'* (*'Cancer, Disease Of The Soul, Short-Circuit In The Brain'*) I described HH's in the conflict-active phase as 'short-circuits' because we knew nothing of the bioelectric processes. I no longer call them this because a short-circuit is generally considered to be a 'disturbance of the program. This is only partially true in the case of an HH. We could call it a disturbance of the normal program, but one for which the organism is already prepared in the possibility of an event.

However, even the word 'disturbance' is not really adequate for this 'emergency' or 'extraordinary', program. When an individual gets caught 'on the wrong foot' in a situation not anticipated, an emergency program is set in motion, what we call a 'biological conflict,' whose aim it is to return the individual to his normal rhythm. This program can apply not just to individuals but depending on the situation, to several individuals, an entire family or even a tribe.

An example: a mother sees her 3-year old son have an accident and lose consciousness right before her eyes. If this is a DHS for the mother, it causes a biological conflict, specifically, a mother-child worry-conflict. This conflict has particular significance on three levels. On the psychological level all her mental and physical activity circles around restoring health to the child. At the cerebral level, if the woman is right-handed, there is a target-like HH on the right side of the cerebellum showing an active mother-child conflict. On the organic level, the breast gland tissue of the mother's breast is growing, increasing the size of the left breast to some extent. It is common in nature and in primitive societies for the mother to produce more milk so that the child can heal faster. When the child is well and the conflict-solution sets in, the extra milk-glands are no longer needed because the child can make do with the regular amount of milk. The return to normal results in the mother getting tuberculosis and the child receiving tuberculotic milk that does not harm him. The tuberculosis caseates the newly grown breast gland cells and breaks them up. What remains is a cavity.

What are these HH's in the brain that are already in a healing phase when they are visible but are called brain tumors or brain metastases by radiologists? When they are less clearly marked, they elicit only perplexity. The HH's that show marked perifocal edema

and take contrast medium well are identified as rapidly growing tumors, but if there is a marked edema and no visible HH, as usually happens with medullary HH's, then again there is general helplessness among radiologists. If the HH's are on the cortex, they are then misdiagnosed as inflammation of the meninges; however they are all one and the same - different stages in the development of an HH.

The HH's in the conflict-active phase, namely, in target configuration, have been misinterpreted as artifacts inherent to the equipment. Later on, as they develop edema and become the so-called brain tumors, the radiologists do not bother to establish that the supposed brain tumor had already been visible in target configuration, i.e. as an HH in the conflict-active phase. The signing of the protocol with Siemens mentioned at the beginning of this chapter finally put an end to the controversy regarding the alleged artifacts. They are now facts: a target configuration means a conflict-active phase in a specific relay or group of relays in the brain.

There are no brain tumors by definition: under no conditions whatsoever can brain cells divide after birth, not even under conditions diagnosed until now as brain tumors. What can multiply is glia, the connective tissue of the brain, which has exactly the same function as the connective tissue in the body. No one can place the developmental-evolutionary history of glial cells with any certainty. Based on their role in the brain, there is a strong suspicion of a mesodermal origin for them. On that basis, it would follow that the glial structures occur only in the healing phase in the brain relays. We know, on the other hand, that neurofibromas originate in the conflict active stage and consequently cause cell multiplication. This is not a contradiction, however, since we know that the mesoderm covers the organs directed by the cerebellum as well as those directed by the cerebral medulla. The first generates cell multiplication in the conflict-active phase while the second generates cell multiplication in the healing phase. We have to accept, therefore, that gliomas have both capabilities of the mesoderm. These clear HH's, dense with glial cells, are the repair works of the organism on the HH. They represent grounds for relief, not fear and an operation on the brain.

Let us retrace this development:
When a DHS occurs, the appropriate relay centre in the brain is marked and the HH takes on a target configuration. If we see this target configuration on a CT, we know that there is a special program running in this relay, meaning that in this conflict, the brain and the organism were caught on the wrong foot and the special program was switched on.

The special program helps the organism deal with the unexpected situation. This situation may affect not only the individual but possibly also his biological group (tribe, family, etc.) The conflict-activity (target configuration) continues until there is a solution to the conflict, which allows the organism to return to normalcy. Until that is possible, the organism has to pay the price for having initiated the special program through a kind of short-circuit, suggesting a kind of emergency program. The price to pay is the healing phase, or the repair of the psychic, cerebral and organ levels, in order that the former, hopefully optimal, state may be regained. It is only when all three levels have been repaired that the organism can return to normalcy. We can think in terms of the brain relay as being in a 'compassionate' state while the special program in the HH is in the form of a target configuration, the conflict-active phase, which state is also called 'lasting sympathicotonia'.

We can imagine it as an overly strong current of great pressure being forced through a conduit that is too narrow. The conduit gets burned and leads to isolation. It is slightly different in bioelectricity so we should imagine the brain cells as an endlessly complicated network of grids. The standing sympathicotonia, something planned in principle (although a bit too much of a good thing), causes the communications conduits of the brain nerves to

become more and more damaged. This corresponds exactly to the organ in the body that is enlarged, shrunk or altered because of the cancer, in order to deal with the new unexpected situation. Nothing really exciting happens in the HH, as far as the CT is concerned, other than that the target configuration remains constant. We can see in the nuclear resonance scan (MRI) that there is a totally routine change in the immediate environment.

In fact, the reality is totally different, for it is in the PCL-phase that we can establish the magnitude and extent of the damage because the organism starts its repair of this special program at the very beginning of the PCL-phase, either by cell-multiplication or by cell reduction of the body organ and of the affected relay in the brain.

13.3.1 In summary, the events that take place after a DHS on the three levels of our organism are as follows

Psychological:

A. Conflict-active phase (CA-phase):
Standing sympathicotonia, i.e. maximum stress. The patient dwells on his conflict day and night, trying to resolve it. He can't sleep, and if he does, it is only for the first half of the night, in half hours. He loses weight and has no appetite.

B. Conflict resolution phase (PCL-phase):
There is peace. The psyche has to recover. The patient is worn out and tired, but feels liberated, has a good appetite, is hot, and has frequent fever and headaches. He sleeps well but often not until 3 a.m. Nature has arranged this mechanism so that people in vagotony sleep only from daybreak to avoid potential dangers (predators) while asleep. All patients like sleeping a lot during the day.

Cerebral:

A. Conflict-active phase (CA-phase):
Target configuration in the corresponding HH (see chart) that means there is a special program running.

B. Conflict resolution phase (PCL-phase):
Repair of the HH through development of edema and accumulation of glia in the vicinity of the affected relay. This leads to re-establishment of the prior condition that is important for future conflicts but is at a price because the tissue is less elastic than before.

Organic:

A. Conflict-active phase (CA-phase):
According to the chart and the ontogenetic system of tumors and cancer equivalents, there is either cell increase during the conflict active phase, with a very specific purpose, or a cell necrosis, or hole, also with a definite biological purpose. This purpose consists in using the organic change to resolve the surprise situation we call the biological conflict. The biological purpose of a coronary ulcer, for instance, is that of expanding the coronary arteries to allow more blood to flow through, thus increasing the strength and endurance of the individual. A multiplication of the breast gland cells serves the purpose of providing more milk for the child and speeds the child's healing after an accident.

B. Conflict resolution phase (PCL-phase):
Repair of the cancerous tumor through microbial decomposition, and of the cancerous ulceration through microbial reconstruction (see chart and diagram of the ontogenetic system of tumors and cancer equivalents). Edema found in the brain and on the organ is always a sign of healing.

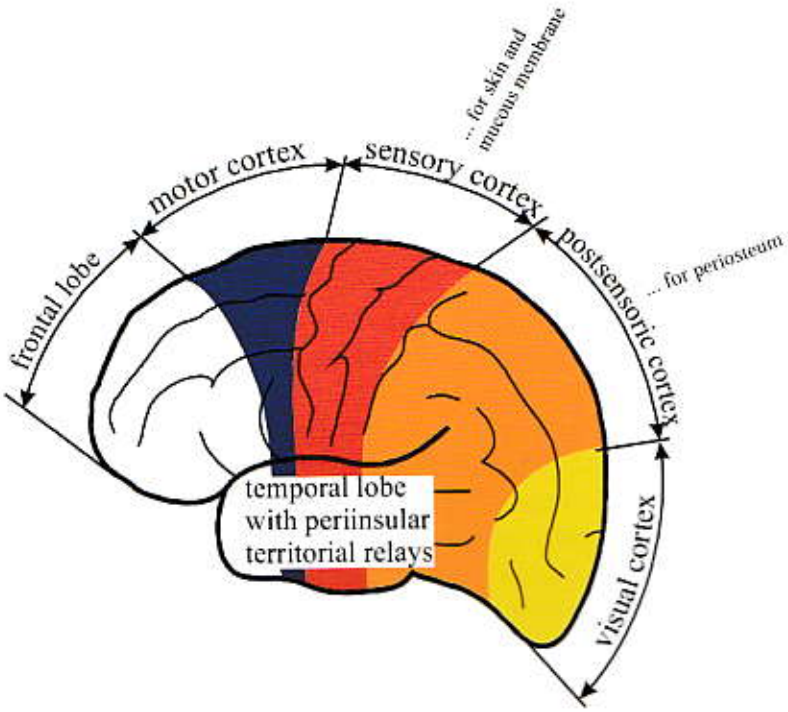
The following are a number of illustrations and typical HH's in various phases as examples to support my statements:

The brain from the left side as if its substance were transparent and the ventricles and chambers could be seen. In the centre are the two lateral ventricles that communicate with each other through the third ventricle, visible below. The cerebral-spinal fluid flows from the third ventricle through the aqueduct into the fourth ventricle visible on the top of the lower pons and the superior medulla oblongata.

The lateral ventricles consist of the anterior horn (frontal) and the posterior horn (occipital) and the inferior or temporal horn, which run on the right and left outside along the temporal surface.

The whole ventricular system is in communication. The cerebral-spinal fluid is produced in the choroid plexus and flows through the aqueduct into the spinal canal.

If there is compression in the midbrain or the pons (brainstem) pressing on the aqueduct, the fluid in the ventricular system will be obstructed from the first to the third ventricles where we will find a so-called internal hydrocephalus. If an HH requires space in the cerebrum during the healing phase, then there is usually compression only on the neighbouring lateral ventricle. In the case of childhood leukaemia, the pressure on the overall ventricular system of the first three ventricles is often so great - through the generalized medullary edema - that the ventricles in a brain CT can only be recognized with great difficulty.

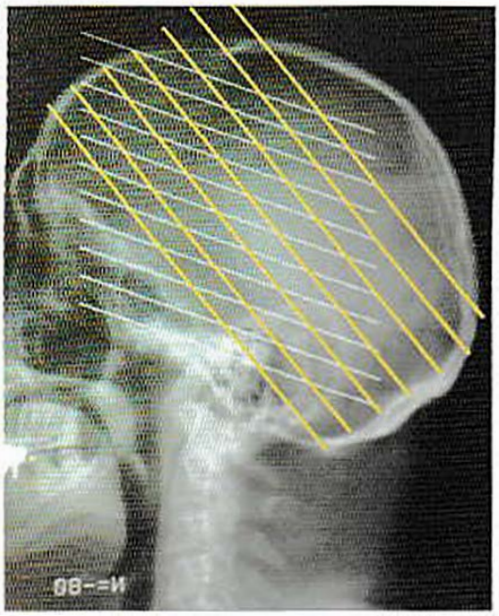


The above figure shows the current internationally used so-called functional zones of the giri, which are divided into brain lobes by major sulci. Here the cerebral cortex is seen from the right.

The left side contains the relays for the thyroid ducts, the larynx, the cervix and uterine opening, vagina, rectum and female bladder, for both right and left-handed individuals.

The right side contains the relays for ducts of the pharyngeal arch, bronchi, coronary arteries, stomach mucosa of the small curvature, duodenal bulb, hepatic ducts, pancreatic ducts and the male bladder for right and left-handed individuals.

13.4 Our brain



Modern methods of computer tomography allow us to practically look into the human brain as we investigate it in layers. The desired layer can be set up and photographed, vertically or horizontally. The above picture shows the standard layers that run nearly parallel to the base of the cranium.

The various layers permit us to obtain a series of photographs showing various parts of the brain and possible HH's.

13.5 The clapping test

linke Hand oben =
Linkshänder

rechte Hand oben =
Rechtshänder

The clapping test is the easiest way to test right and left-handedness. It must precede an evaluation of a brain CT. The upper hand is the leading one and determines the patient's laterality.

a) brainstem: the deep regions of the pons are unpaired from a functional point of view, not from the anatomical point of view, i.e. the conflicts of the gastro-intestinal tract appear in a counter clockwise manner (mouth, oesophagus, alveoli, stomach, liver, pancreas, small intestine, large intestine, rectum, urinary bladder (trigonium portion) and ovarial ducts) showing up from medial-dorsal laterally to the right, then medial-ventrally, to the left laterally then to medial dorsal (see the brain-stem diagram Chapter 'The Diseases of the Inner Germ Layer'). However, the transition zones (the angle of the cerebellum pons) already show pairing (e.g. the nucleus of the acoustic nerve). The acoustic nuclei innervate the middle ear in the case of a biological conflict of 'not having obtained the auditive morsel, not having received the information', but they do not cross over to the organ. The relays located in the midbrain, all the way to the brain medulla bordering at the relays for the kidney parenchyma, are paired but do not cross over.

b) Right or left-handedness becomes significant from the cerebellum onwards. From here on, all relays of the cerebellum and the complete cerebrum show a crossed-over

correlation to the organ. Even so, the cerebellum and the cerebrum are different from each other even though the handedness applies to both. The conflicts of the cerebellum impact strongly on correspondence of the conflict contents in relationship to the organ, i.e. the cerebellum sides are each bound on the basis of conflict theme. A mother child worry conflict always impacts right-laterally in the cerebellum for a right-handed woman on the glands of the left breast. If the patient suffers another conflict for another child, or a mother-child conflict with regard to her own mother, the impact is still on the same cerebellum relay as the new HH. Even if she suffers another two conflicts of an attack against the left abdomen or breast side (peritoneal and mesothelioma of the pleura), they all impact on the right side of the cerebellum, which would show five HH's in target configuration, and not even one on the left side. Two conflicts on two separate hemispheres of the cerebellum are known as 'cerebellar schizophrenic' constellation. There is profound emotional disturbance in terms of paranoia but no effect on formal-logical thinking ability: e.g. „I am burnt out; I feel completely empty, I have no more feelings".

c) This would also be possible in the cerebral medulla. The conflict contents and the organ correlation are always unequivocal, i.e. bound by conflict theme.

d) In the case of the relays of the cerebral cortex, this is only possible with one exception: the ductal milk-tubule-ulcerating-carcinoma which, with regard to laterality, is strongly coupled to the cerebellum relays for the breast glands. There is a totally new element at play here; for the cerebellar cortex directed conflicts, the correlation to the organ is no longer unequivocal as was the case in the cerebellum. The organs are only paired in part; it is the laterality, as well as the momentary conflict situation that determines which relay can become the HH in the moment and affecting the correlated organ. The correlation between the brain and the organ, on the other hand, is always unequivocal. Therefore: if a left-handed woman suffers an identity conflict, the HH impacts on the right side temporally and at the organic level becomes stomach or gall-duct ulceration. If she then suffers another identity conflict for some new reason, she cannot react on the right brain hemisphere cortically, so she suffers the second identity conflict temporally on the left side; on the organ level she suffers a rectal ulceration and in the PCL phase this becomes haemorrhoids if the ulceration was in the proximity of the anus. The patient is in schizophrenic constellation for as long as the two conflicts (right and left cortical) are active. The questions - how the conflict is experienced (in a male or female fashion) and where it impacts on the brain - depend not only on the hormonal state (post-menopausal, pregnancy, contraceptive pills, ovarian necrosis, etc.) but also on the laterality of the patient. In the same way that the conflicts change, they can also be robbed of their meaning-contents if the preconditions (actual conflict constellation, hormonal situation, etc) have changed. They can then 'jump', i.e. a rectal ulcer can become a stomach ulcer and vice versa.

The correlation between the brain and the organ, however, is always unequivocal - once the conflict has impacted, it is the specific correlated organ that is affected for as long as the conflict is active and has not 'jumped' to the other hemisphere through a change of the hormonal and conflictive constellation prerequisites.

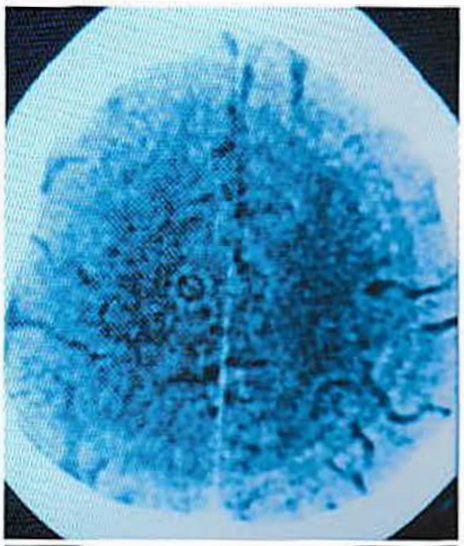


Plate 1:
Typical target configuration of an HH - i.e. CA-phase in the sensory cortical field with its centre lying paramedially on the left. This leads to a sensory paralysis of the right leg and (to a lesser extent) the right arm. The fact that the rings of the target configuration reach over to the right side of the brain as well as the motor cortical centre and the post sensory (affecting the periosteum) shows that even the left side of the body is affected, as are motor and periosteum sensitivity.

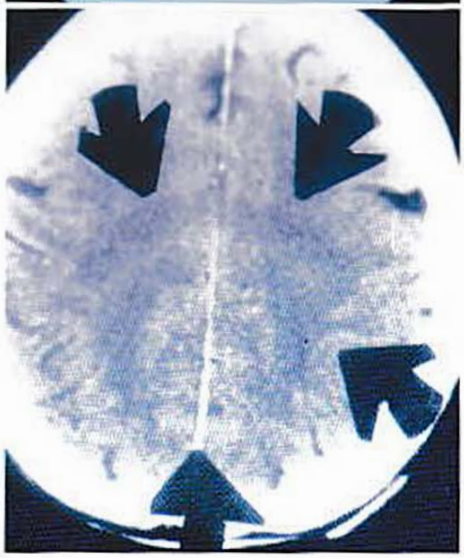
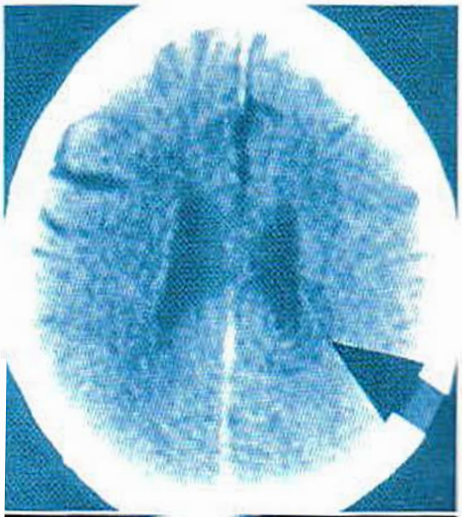


Plate 2:
HH central in the post-sensory (applicable to the periosteum) cortical centre in the PCL-phase (healing phase). The target rings show edema.



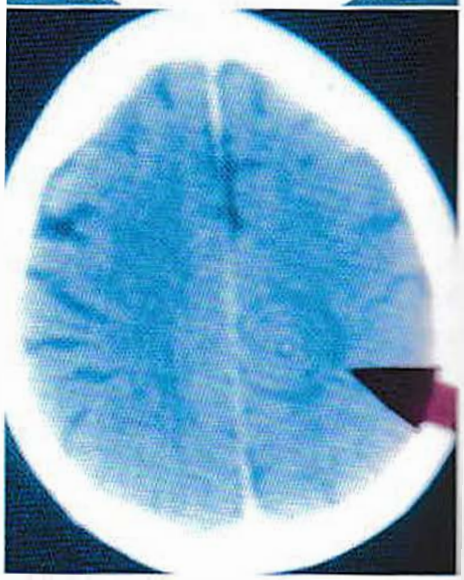
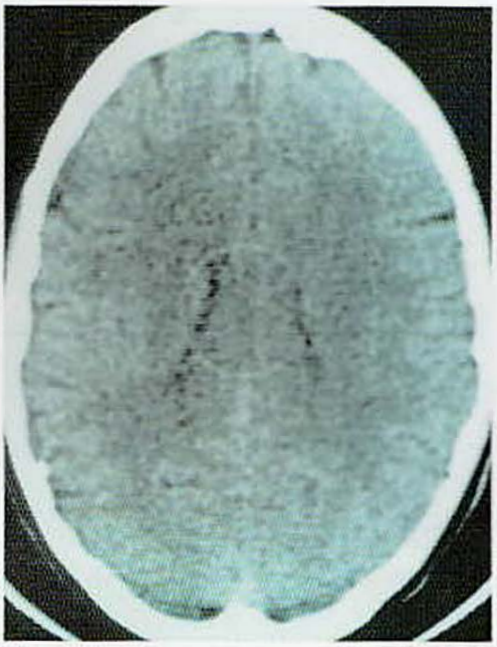
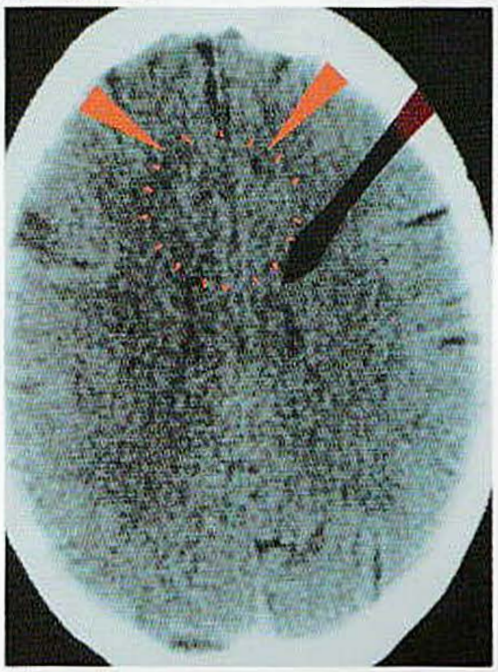


Plate 3 and 3a:
Same patient, same CT, different layers. HH in the CA-phase, partially projecting into the cerebral medulla but belonging to the post-sensory cortex (painful separation conflict affecting the left leg [periosteum]). A ring is already visible as going into resolution, which means it was spotted during the conflictolysis.

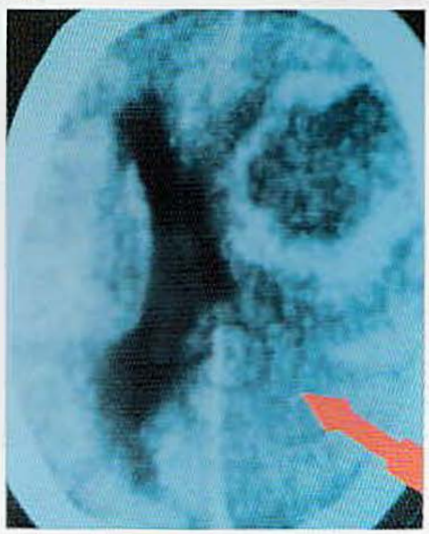
Plate 4: CT of 7/5/1990 - Plate 5 CT of 3/7/1990
CT of 7/5/1990.





A 60-year-old patient, wife of a university rector who had left her 15 years earlier. Divorce not permitted for religious reasons. Five years earlier, the woman had met another man who was not yet divorced. He did get divorced in 1989, but the patient could not persuade herself to divorce her husband and marry him. The man chose to move in with another woman. The patient suffered a DHS conflict of not being able to hold onto the man, and a separation conflict because he had slipped from her hands. The patient suffered a motoric and partial sensory paralysis involving both hands with almost total motor paralysis of the right thumb. MS was suspected. The woman's daughter, a professor of neurology, asked me for advice. On the basis of the CT she had brought we reconstructed the case very quickly. She gave her mother therapy by discussing the situation in great detail. The paralysis receded. The mother then suffered the obligatory epileptic attack. However, the following then happened: the patient learned that her ex-boyfriend's new partner was not a 'lady', and that she had already been involved with him while he was still intimate with the patient. She suffered a resistance DHS and a fear-revulsion conflict (left-handed), which is centered in the glucagon relay with hypoglycemia outweighing hyperglycemia. We can still see the sharp ring-formation on plate 4 as a sign of the active conflict of the motor and sensory paralysis. This conflict was resolved two months later. However, there is evidence of a new target configuration of an active conflict at this time, that the patient still had resistance and revulsion in the glucagon relays. Intensive discussions were able to resolve this conflict as well.

Plate 6:
HH for large resolved territorial fear conflict (bronchial carcinoma) of an elderly female patient. Also central conflict in the post-sensory cortex in CA-phase. The patient's sister came into the hospital and told her she had seen their mother in a white dress saying she would be coming for her daughter (patient) soon.



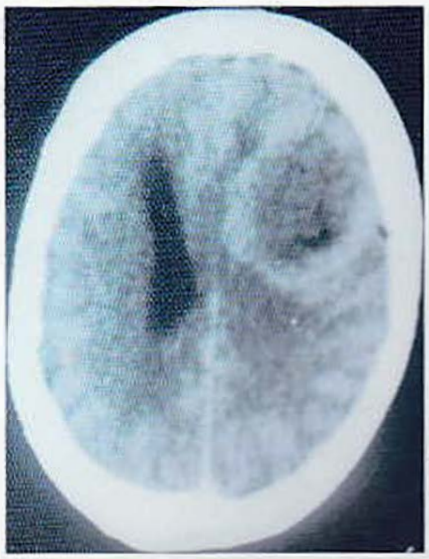


Plate 6a:
The same patient - the HH seen in a higher cross-section.

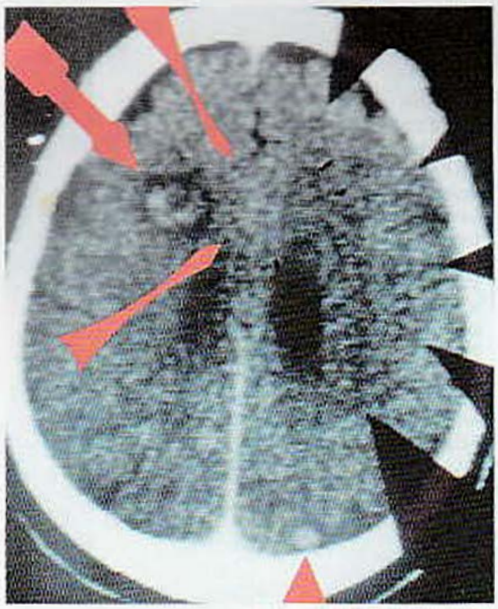


Plate 7:
HH semicircular on the right for motor conflict in the PCL-phase. Right next to it (thin arrows) an HH in CA-phase central in the glucagon relay. Further an HH in an advanced state of healing on the left involving the right shoulder (osteosarcoma caused by a self-devaluation conflict in relation to a partner) and an HH that is almost completely healed in the right visual cortex (fear from behind).

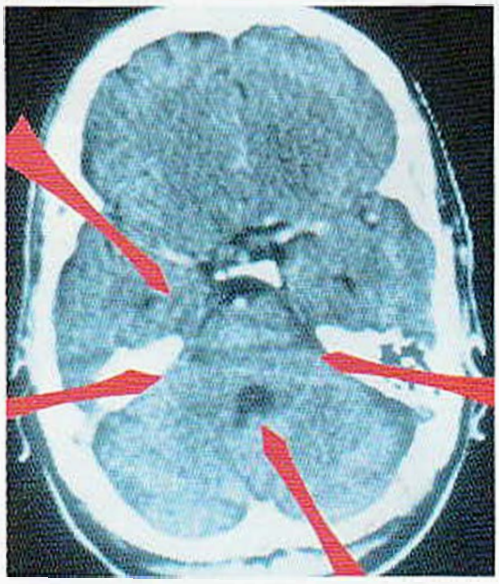


Plate 8 and 9 the same patient.

Plate 8:
Two different HH's showing a sharp target configuration. The arrows point to the relay of the small intestine, revealing an indigestible anger.

Plate 9:
A deeper cross section. Target configuration (same series) but with a different midpoint, namely in the tubules and urinary bladder relay. Conflict: the patient had misguided her horse and injured another rider badly by crushing him against the boards. He swore at her in very violent language (tube Ca), and then on top of that she was responsible for the high cost of his hospitalization that lasted a considerable time.

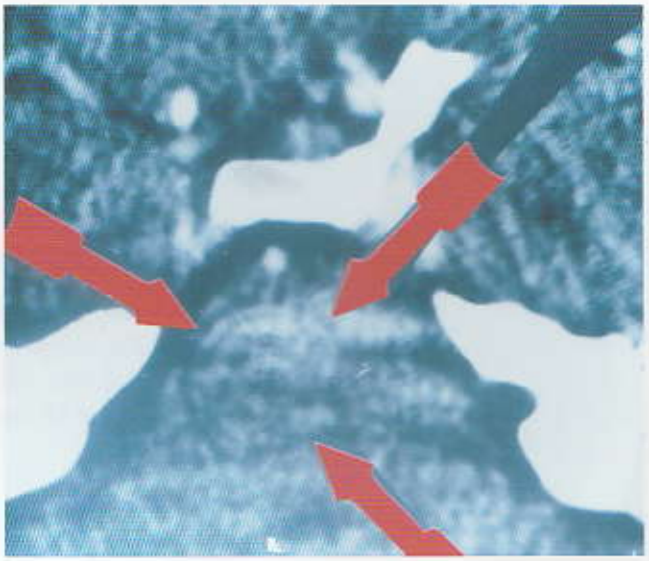


Plate 10:
Resolved HH (PCL-phase) in the sensory cortex left. Perifocal edema and medullary edema.

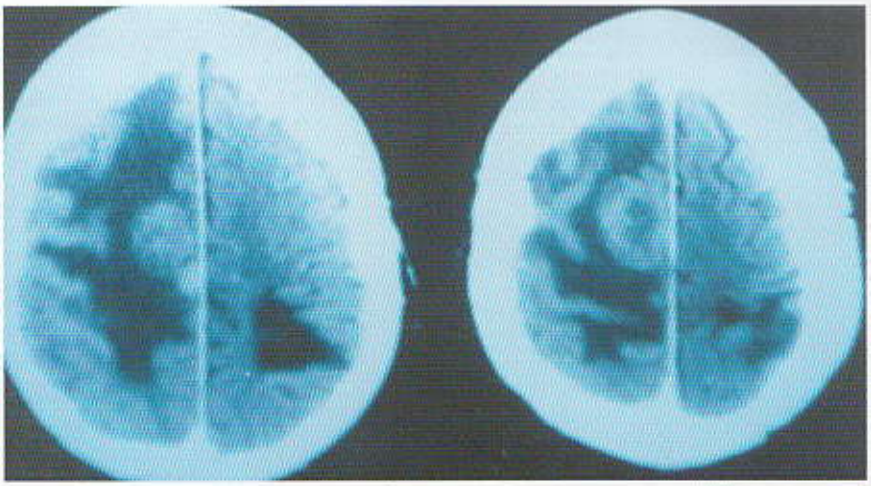
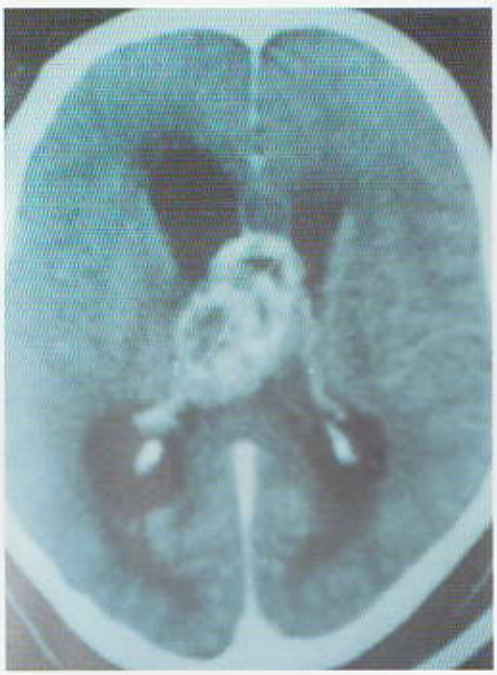
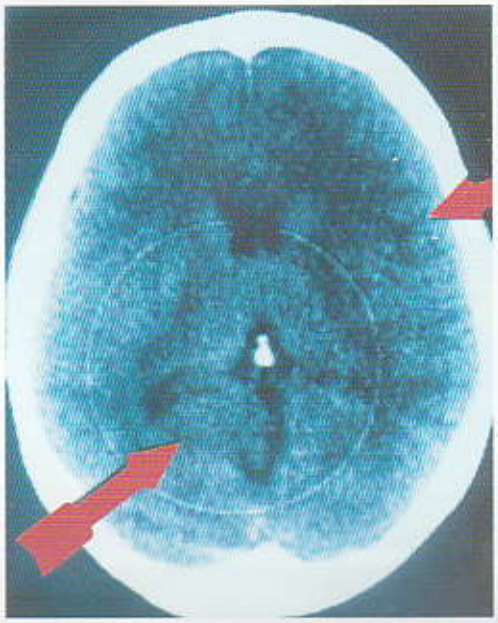


Plate 11:
Circular HH's filled with glia (in the PCL-phase) in the motor and sensory cortex of a patient who could not free himself when his right hand was caught in a circular saw.





Plates 12, 13, and 14 same patient:

The large sharp ring is an artifact. Beside it are two clearly visible HH's in target configuration still in the CA-phase. The right one concerns a heart coronary ulcer (territorial conflict), the left one the right testicle (loss conflict). The patient, very attached to his mother, lost her unexpectedly. One can certainly see that the right target configuration is in the CA-phase. The left one, in contrast, is already somewhat swollen, and on the verge of going into resolution. This patient later suffered a heart attack at the deepest point of the PCL-phase (February 1993).

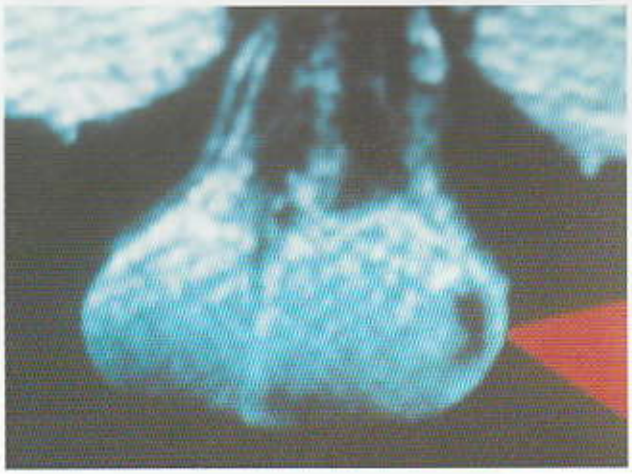


Plate 13:
The same patient, testicular carcinoma of the right testicle.

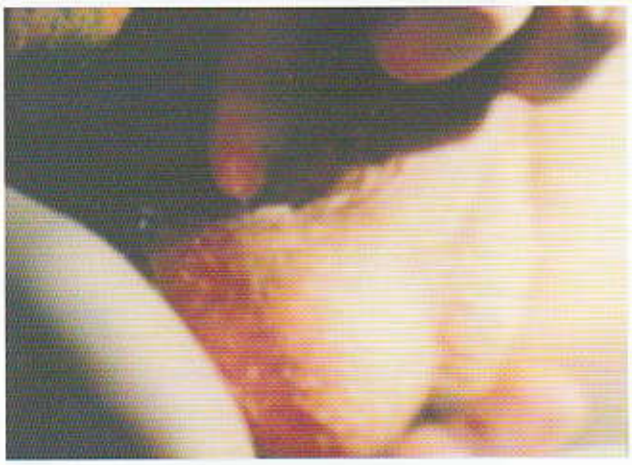


Plate 14:
The right testicle shows practically nothing from the outside. The finger points to the site of the necrosis.

Zentrum für Neue Medizin
in Österreich

Leitung Dr. med. Ryke Geerd HAMER

Burgau,

27. Jenner 1993

Es wird bestätigt, daß bei Hr. [redacted],
allein auf Grund des Hirn CT und Anamnese
ohne daß der Pat außer einem leichten
Ziehen im rechten Hoden über Beschwerden
geklagt hätte, gezielt eine Nekrose im
re Hoden gesucht und CT-mäßig
gefunden bzw verifiziert worden ist.
Entsprechend dem Hirn CT ergibt sich
genau ein Mittelding zwischen
Nekrose (=Aktivphase) und Wiederauffüllung
der Nekrose (=Heilungsphase)

A-8291 BURGAU Altes Schloss 1 Telefon ~~0043/3383/2040~~

gz. Hangl Willibald, Amtsarzt, [illegible]

Centre of NEW MEDICINE in Austria
Directed by Dr. Ryke Geerd Hamer

Burgau

27th January, 1993

This will confirm that we have searched for and verified a right testicular necrosis for Mr. (name covered) on the basis of a brain CT, anamnesis and report of light tension on the right testicle but no complaints of any kind from the patient.

According to the brain CT we can identify a cross between necrosis (active phase) and refilling of the necrosis (healing phase).

Signed Dr. Willibald Stangl, Medical Examiner

A-8291 Burgau, Altes Schloss Tel: 00483383/2040

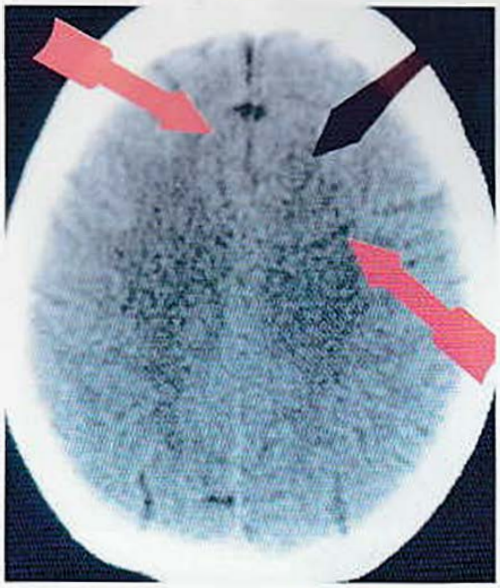


Plate 16:
25/1/1990 CA-phase.

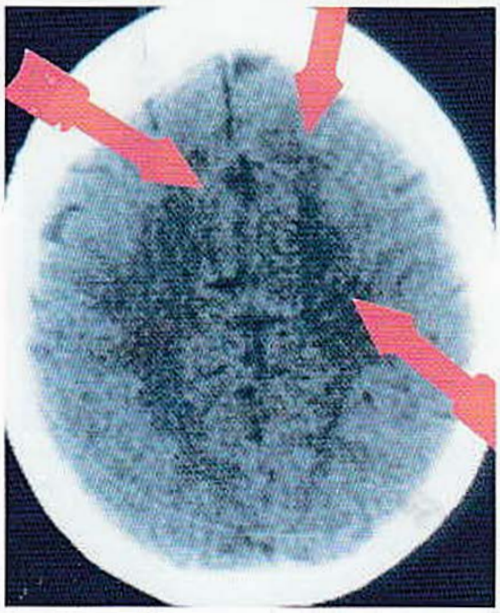


Plate 17:
25/2/1990 immediately after CL.

Plate 18:
10/4/1990 end of the PCL-phase.

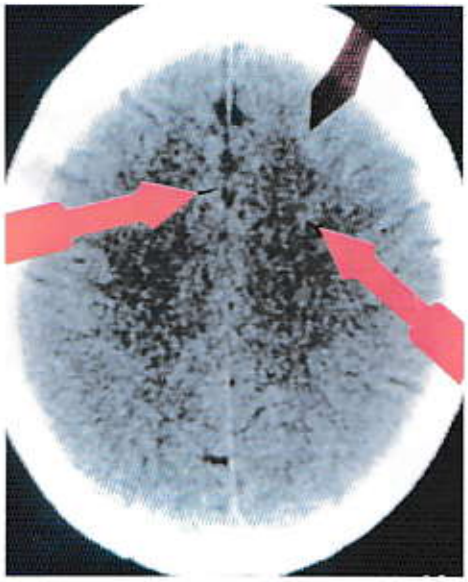


Plate 19:
Photograph of a left-handed patient.

The three previous plates show the development of an HH.

As we can see, the patient is left-handed. She became ill with a partial paralysis of the left arm and leg and, to a lesser extent, the right arm. DHS in June 1989: unhappily married, this patient lost her boyfriend whom she could not 'hold onto' in a left arm (and leg) embrace (left-handed) (much less the right extremities). (These are the partner arm and leg). She could hold him even less with her right arm (mother-child). She had wanted his child and had hoped to become pregnant, which is why the loss was so dramatic.

The first CT shows the conflict is still active. We see the sharp circles of the target configuration of the HH and the rings extending to the left side (weak paralysis of the right arm). The centre is on the right, in the motor centre, affecting motor cortex for the partner embrace with the left arm (left-handed) and the intimate partner embrace with the left leg. The conflict resolution was achieved through co-operation with the family doctor excited by the NEW MEDICINE on 20/2/1990, just four weeks after the first CT. This second CT of the same layer shows the HH as it is 'breaking up', i.e. the rings become irregular and incomplete on the outside, but we can still see the centre.

The last plate, also of approximately the same layer, even if not at exactly the same angle of inclination.

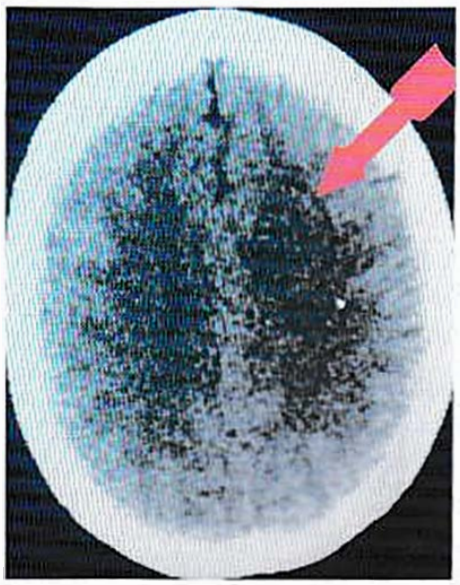


Plate 20:

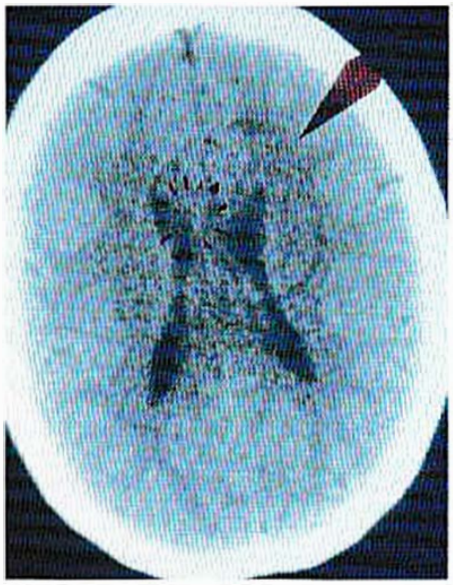


Plate 21:

which allows the HH to slide forwards or backwards a little bit. We can see that the HH has begun to form glial scarring. I should also mention that the patient had an epileptic attack (epileptoid crisis) on 10/3/1990, which did not surprise her, since her doctor had fully explained the rules of the NEW MEDICINE. Between July 1989 and February 1990 there was a suspicion that the patient was suffering from MS. Luckily, it was easy to convince her that this was nonsense: the biggest danger is always a secondary motor conflict suffered from the shock of the diagnosis, principally involving the legs because she is told that she will be confined [p.116] to a wheelchair for the rest of her life. This is a conflict that is usually difficult to resolve.

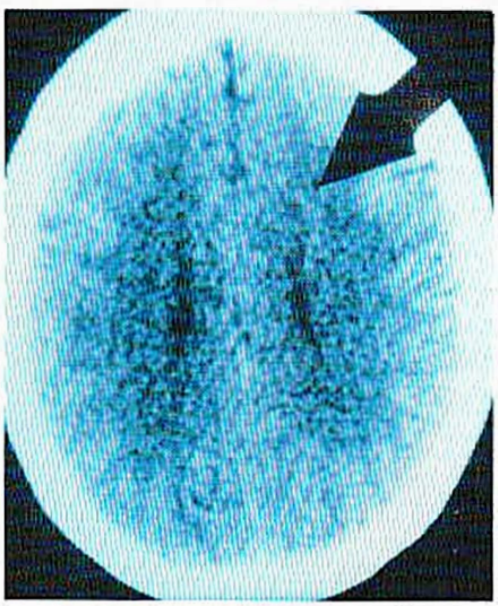
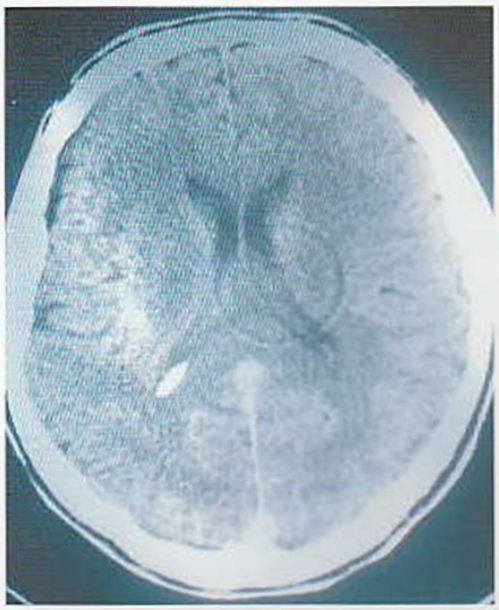
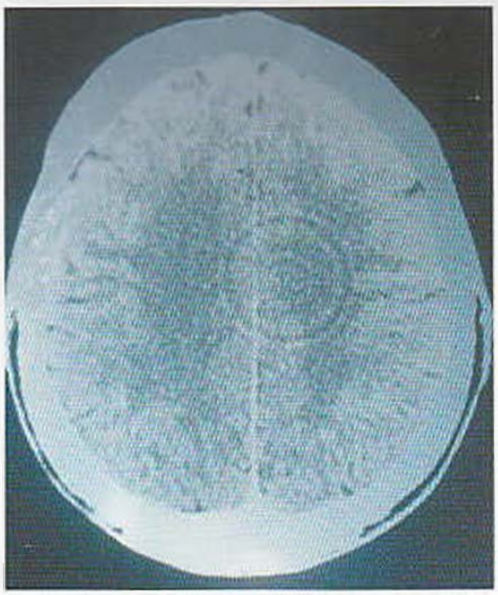


Plate 22:
CT plate of 24/4/1990. The same patient three months later. We can see that the target configuration has a slight 'prickly pear' formation, i.e. the height of the PCL-edema phase is already over.

Plate 23:
The photograph shows the patient demonstrating the partial paralysis of the left leg. Plates 24 and 25 show the target configuration that radiologists would consider an artifact.





Plates 24 and 25:
HH in active phase in sharp target configuration corresponding to motor paralysis, sensory loss and periosteal sensoric partial paralysis. After a fight, the patient's wife angrily threw her wedding ring at his feet. „I stood as if rooted to the spot and couldn't move", he said. His wife came back a week later and the next scan shows that the target configuration had (logically) disappeared.

The patient suffered motor paralysis and periosteal sensoric partial paralysis of the left leg and left arm (conflict of not knowing which way to turn with a brutal separation). CL: a week later, the wife came back and the next scan showed that the target configuration was beginning to disappear.

Plates 26, 27, 28 and 29:
Series of CT's of a female patient with an interval of six weeks. It refers to a conflict of fear-revulsion and avoidance of her boss who was gay and whom she found vulgar and revolting.

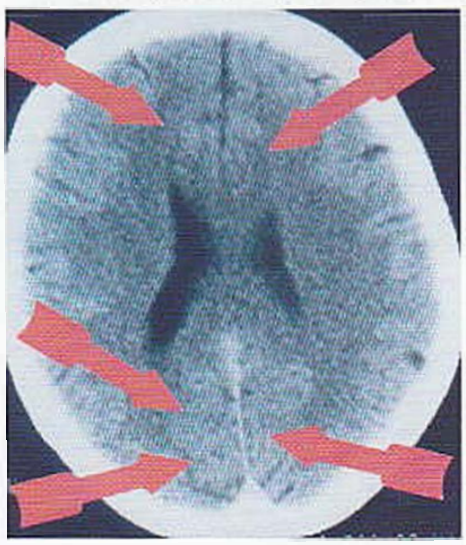


Plate 26 of 24/1/90 in CA-phase:
The centre of the target configuration is located on the right. This is why diabetes outweighs hypoglycaemia - i.e. the beta islet cell insufficiency opposite the alpha islet cell insufficiency. She gave notice shortly after this picture. The same plate shows a large HH dorsally, which has already become a scar but reinitiating the target configuration that shows repeated scarring, in renewed target configuration in connection with both vitreous bodies on the organic level. The biological conflict: the year before, on her way to work at a pharmacy, she had been followed, assaulted and threatened with a knife. The relapse: she had to take the same way to and from the pharmacy every day, and suffered a bilateral glaucoma.

Plate 27 and 28 of 15/3/90:

Both conflicts are in the PCL-phase, the frontal one more than the occipital one. We can see, however, that the edematized target rings are at the same stage. We call this the normal development of the HH after resolution of the conflict.

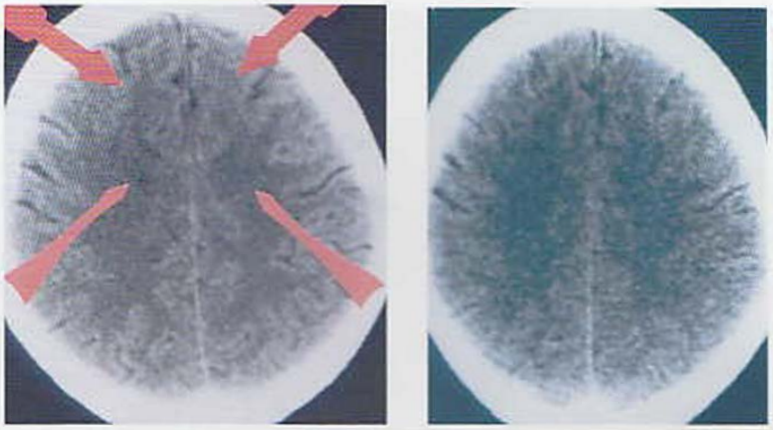


Plate 29:
CT of the same patient 2 1/2 months later. We see only a scar of the tissue in the relay for diabetes/hypoglycaemia.

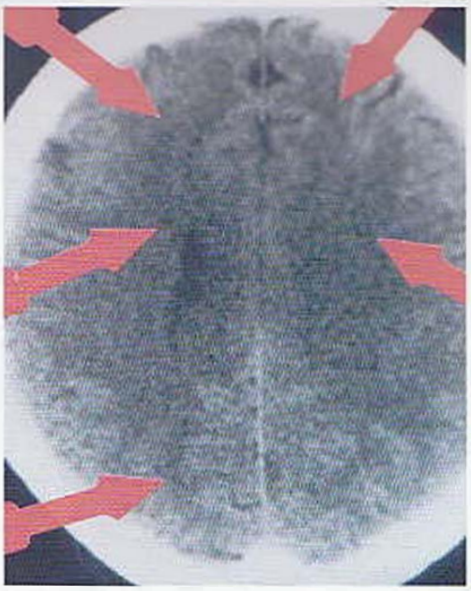
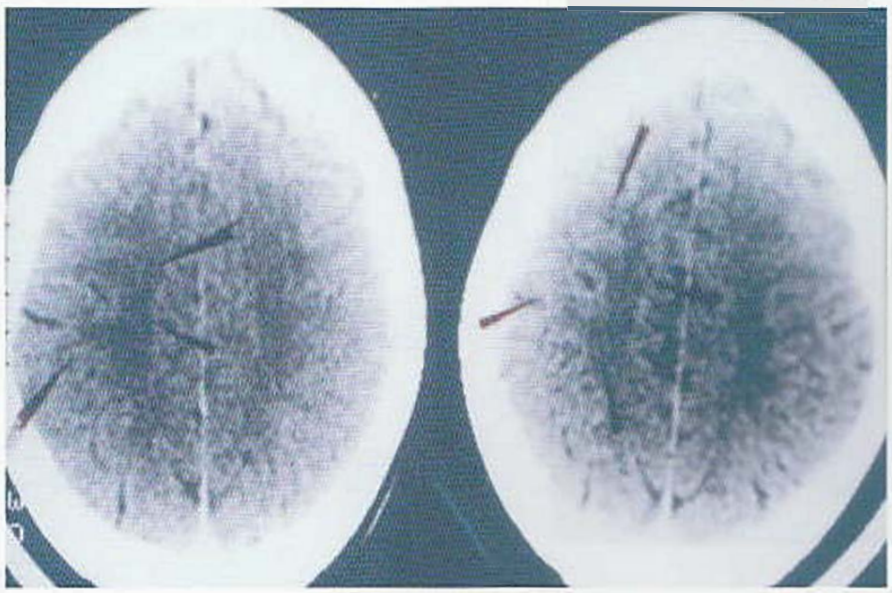
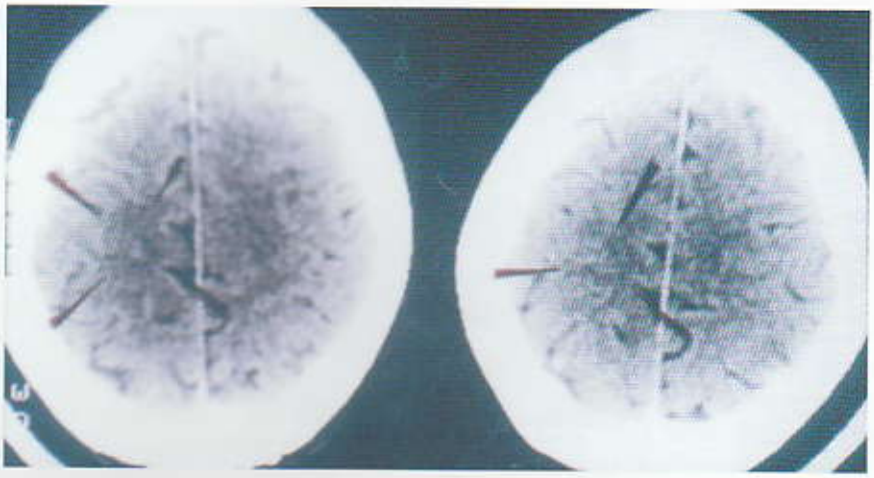
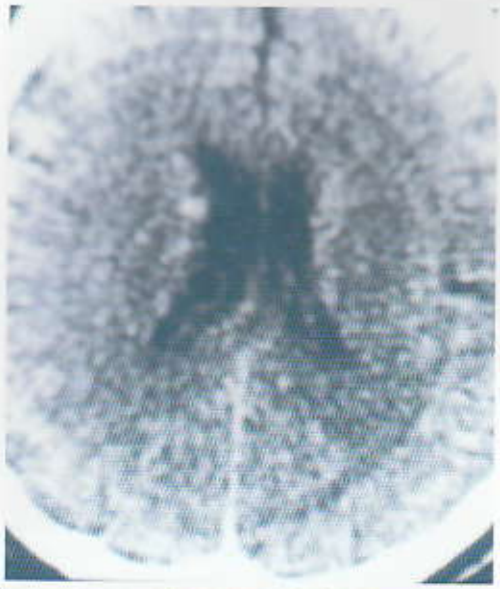
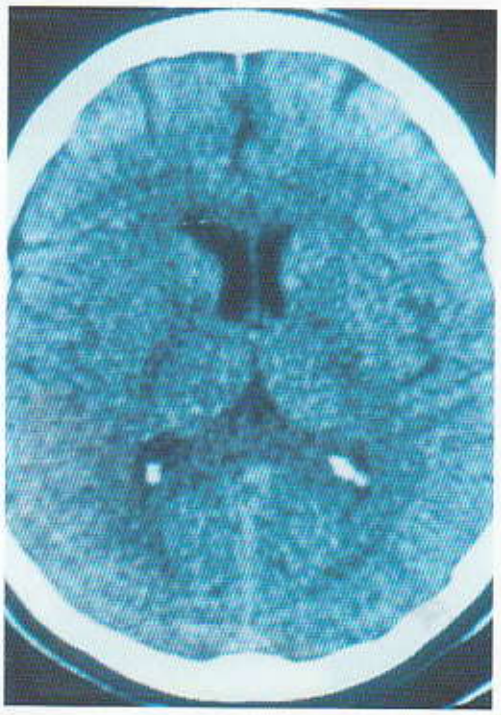


Plate 30-33:
A series of four CT's of a young woman with mammary duct Ca in recent PCL-phase. The radiologist shifted the patient once 2 cm to the right of centre line (plates 30 and 32) and once 2 cm to the left (Plate 31 and 33). As can be seen, the HH did not change as a consequence.



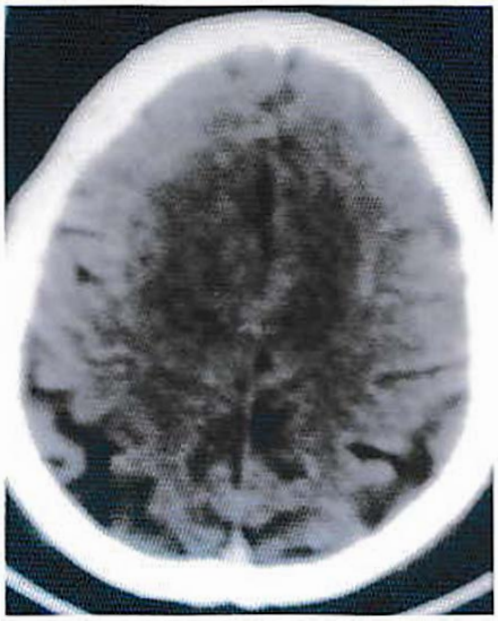






Plates 34 and 35:
These CT's belong to another patient. We can see these are not artifacts because the rings are quite different; they can be seen very well in the comparable centres. Artifacts would look the same, independent of the layer.

Plate 36:



(Plate 36-42)
A whole series of CT's of a banker in a London hospital. A typical case of misdiagnosis. After a dramatic argument with his supervisor that cost him a promotion, the patient suffered a motor paralysis more of the right leg than of the left and also more of the right arm than of the left. An examination revealed an old pancreatic carcinoma and an old liver carcinoma. The cancer of the small intestine (plate 41, left upper arrow) and the target configuration (plate 42, left arrow) could not be seen, of course. Plate 41 shows the old solitary Ca-focus in the pancreas and the liver. The corresponding HH laterally on the right of the brain stem (right arrow) has scarring, edema and eventually also a very lightly visible target configuration. It is possible that the old HH had a connection with his occupation (hunger conflict, of not being capable to digest the morsel) and has been reactivated [p.124] (tracks). We therefore have three different target configurations on the same patient, one of which is an old relay that has been scarred over.

While the conflict involving the extremities, stronger on the left than on the right, is already in PCL-phase and has begun to assume a prickly pear shape, i.e. has already passed the climax; the target configuration for the small intestine is fully active. This shows that a conflict involving several aspects need not be resolved at the same time on all levels. One aspect can be solved while another is still active.

Had the NEW MEDICINE been employed, it would have been possible to appreciate that both the pancreas Ca and the liver Ca, running simultaneously, must have had an old history and that there was a potential to reactivate them now as 'tracks'. The cortical motor conflict on the other hand, having already gone through an epileptic crisis (attack of tonic-clonic spasms) had already gone beyond the climax of the PCL-phase. The conflict affecting the small intestine, as mentioned, is still highly active. Coincidentally, the abdominal CT (plate 41) shows the pre-ileus as occlusion of the small intestine. Had this patient been extirpated of a short section of the small intestine, he could have had a very good prognosis. However, the pre-ileus was assumed to be a new liver and pancreas cancer and the patient was declared inoperable. In this case the motor conflict corresponds to the supposition of not being able to climb higher, specifically, that one is tied down, and the cancer of the small intestine is connected with the indigestible anger. We can see that in differential diagnosis the NEW MEDICINE is superior to current medicine.

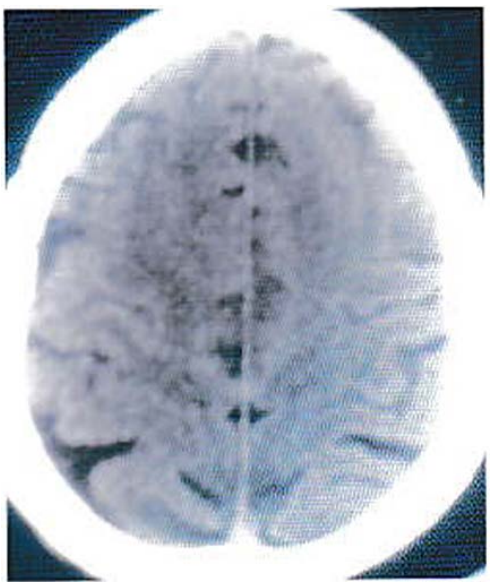


Plate 37:

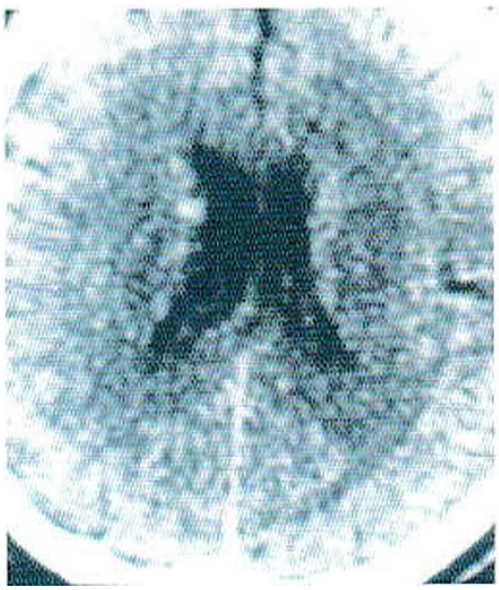


Plate 38:

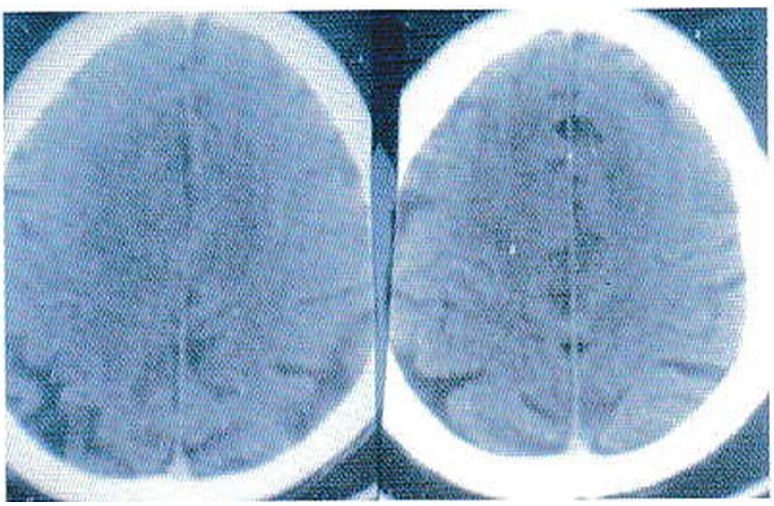


Plate 41:

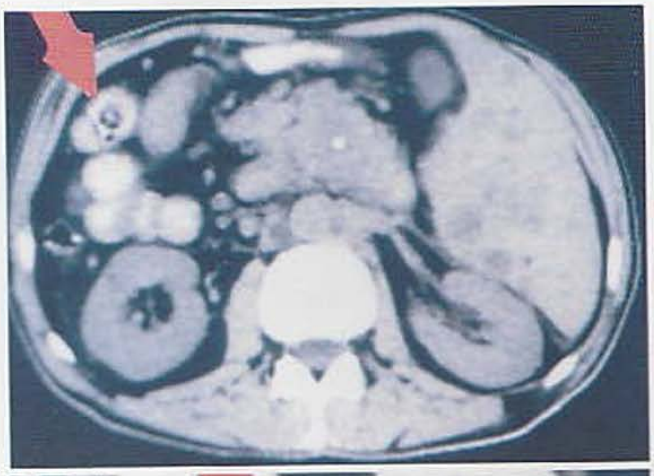
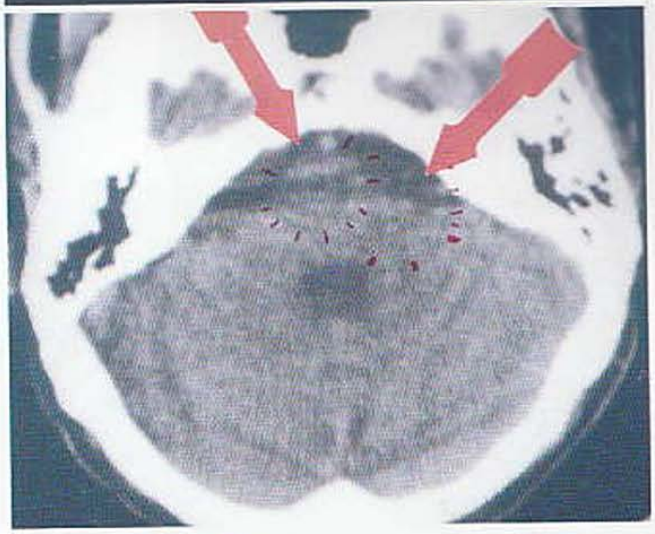


Plate 42:



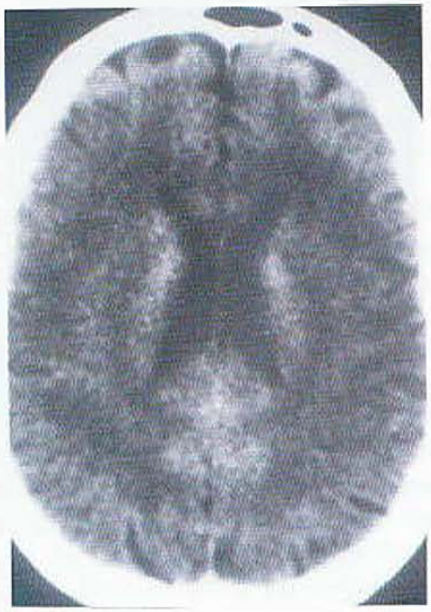


Plate 43:

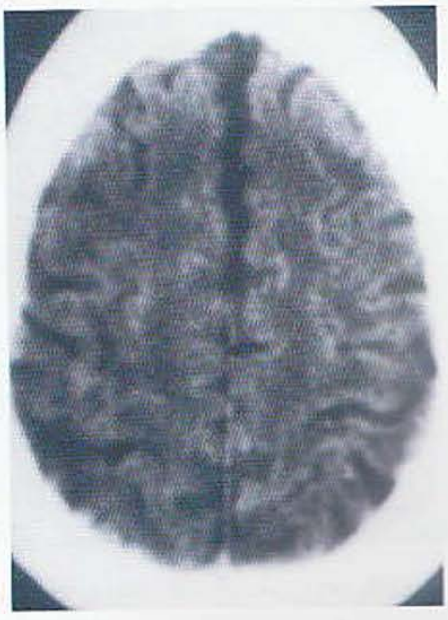


Plate 44:

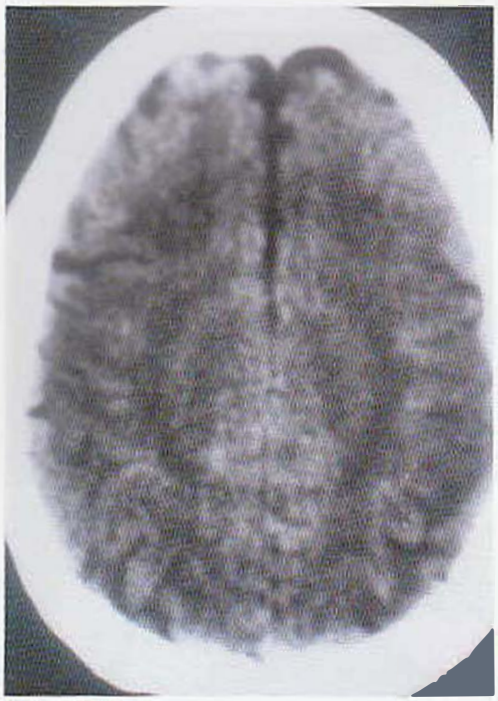


Plate 45:
Series of CT's. In this series we can see very clearly how the target configuration that is edematized in the PCL-phase is clearly visible in one layer but becomes blurred in the other (central periosteum conflict, i.e. resolving brutal separation conflict).

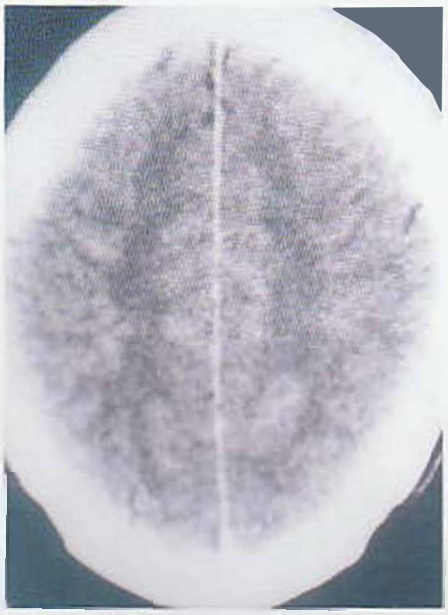


Plate 46:

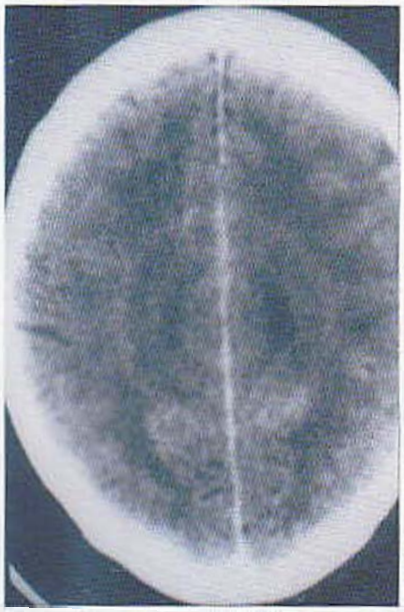


Plate 47:

Sensory, post sensory (Periosteum) separation conflict, already past the high point of the PCL phase. (the organic level: exanthema, urticaria, pruritus) beginning to take on a prickly pear configuration.

Plate 48:
If we have good MRI scans and the conflicts have been active for some time or have been reactivated, we can also see the target configuration on the MRI as demonstrated here: motor conflict left arm, motor conflict right arm and right leg and sensory conflict right arm, post sensory conflict left arm, all conflicts in PCL-phase in a case of MS.

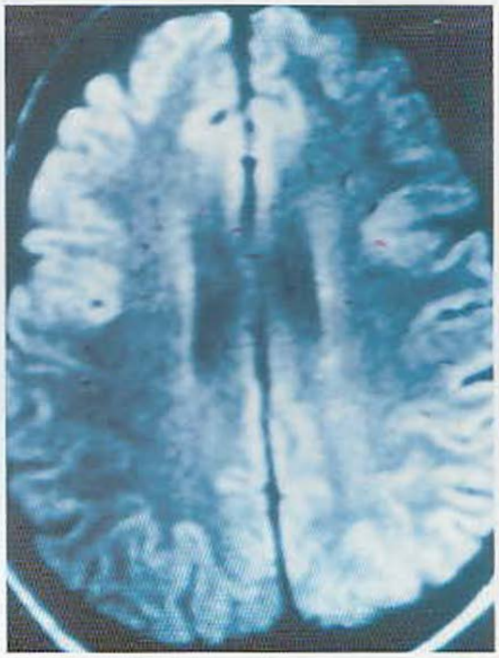


Plate 49, 50:
CT and abdominal CT of a little girl.

Plate 49:
HH in clear target configuration in the relay of the liver (brain-stem laterally right)

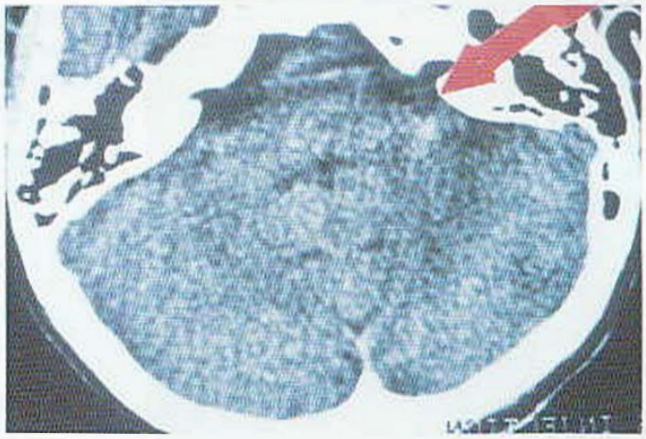
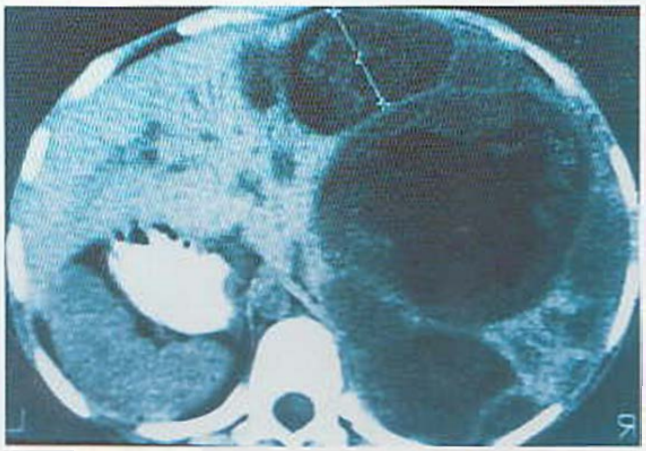
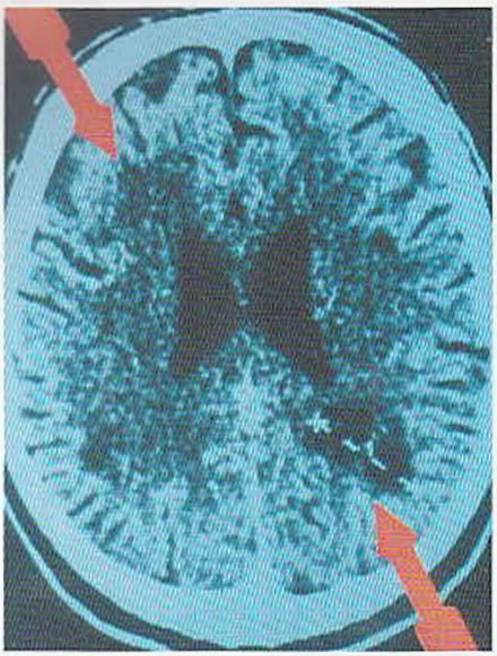


Plate 50:
Corresponding to a so-called solitary liver carcinoma of a little girl in Southern France: conflict: the parents owned a grocery store and when a supermarket opened next door, the father complained: „Oh God, we're going to starve to death!" The five year-old took this literally, and why shouldn't she have? The child died from the fear of starvation.



At first I had great difficulty understanding this kind of scan because, in contrast to the findings of a greatly expanded liver, the brain did not show anything remarkable. However, when we learn to understand the target configuration and can tell the difference between the differentiable formations in the CA and PCL phases, then these scans become brilliantly clear.



Plates 51 and 52 show typical CT's for leukaemia.

Plate 51:
Generalized medullary edema of the brain marrow with special emphasis on the relay for the left neck of the thigh and the relay for the right shoulder after resolved self-devaluation conflict in an old gentleman whose presidency of a committee for the beautification of a village had been taken away. CL.: the mayor personally apologized and reinstated him.

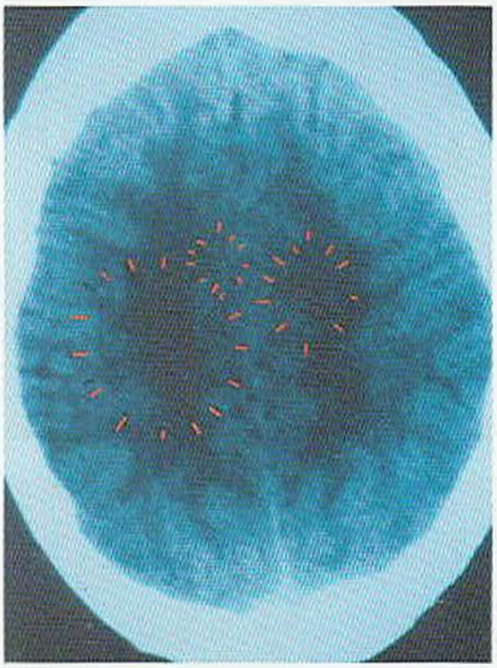


Plate 52:
Generalized medullary edema of a young woman who was a member of a cult and had been 'shipwrecked' in a human and professional way. She managed a fresh start.

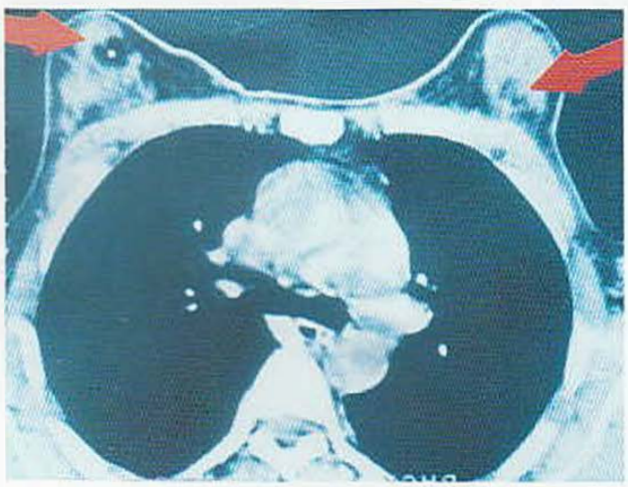


Plate 53:
Right-handed mother with a mother-child conflict that had run its course. She spent some weeks in the PCL-phase with heavy night sweats, i.e. tuberculosis of the left breast. A CT of the pendulous left breast shows the fresh cavern. The right breast shows an older cavern that has been scarred over.

Plate 54:
HH with edema in the right lateral cerebellum (arrows). The picture does not show whether there was tbc helping the caseation of the mammary Ca on the organic level or not; the events in the brain do not change. Also visible is an old scar in the left cerebellum (left arrow) pointing to the earlier mammary Ca of the breast with tbc caseation (partner conflict).

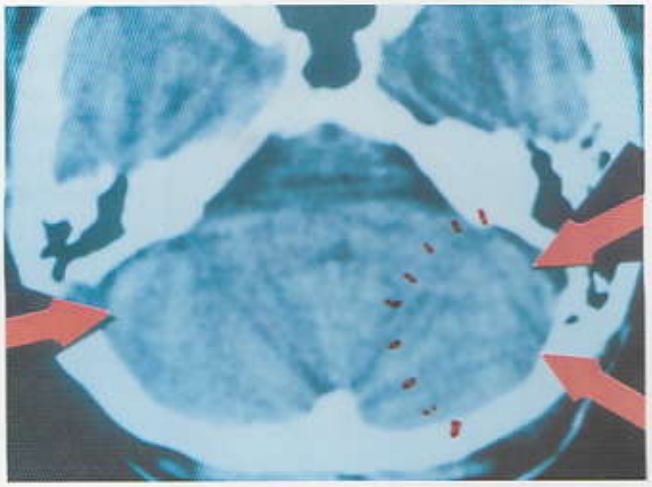


Plate 55:
CT of an elderly patient with a conflict in the periosteum and loss conflict at the end of the PCL-phase. This finding was originally misdiagnosed as a brain tumor. The glial material in the middle of the HH indicates that this process is a recurring one.

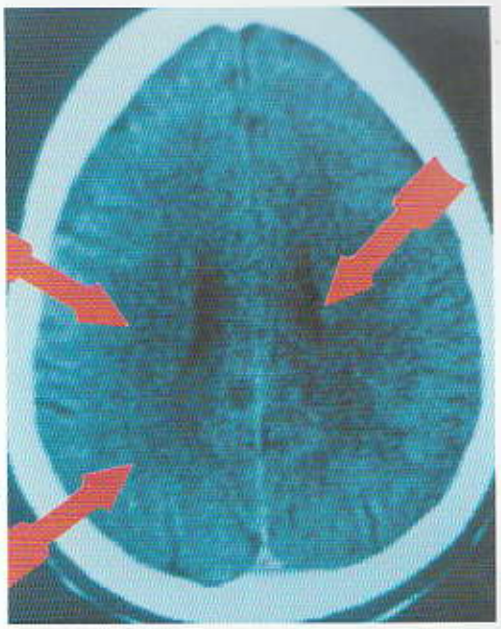
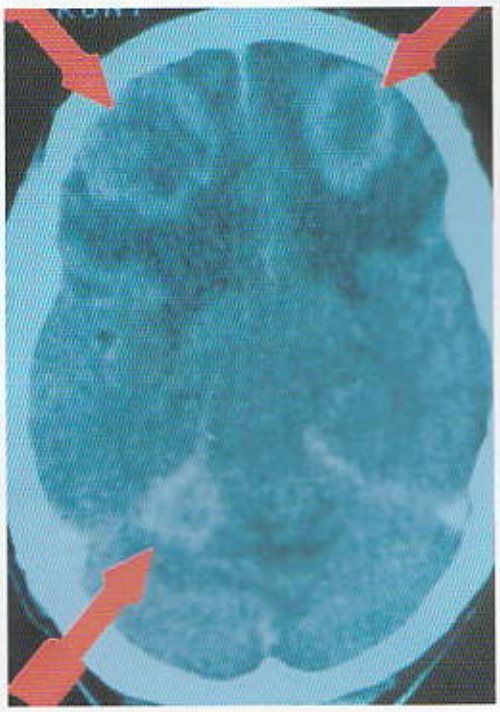


Plate 56:
HH in the PCL-phase (arrows)
Condition after schizophrenic constellation. The brain stem shows a further contrast medium enriched area, referring to a colon-Ca in PCL-phase. This is a labourer from central Germany who suffered anxiety about his job security after German re-unification



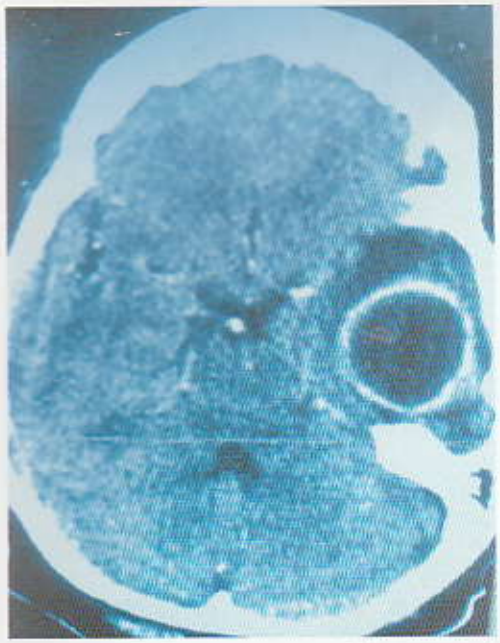
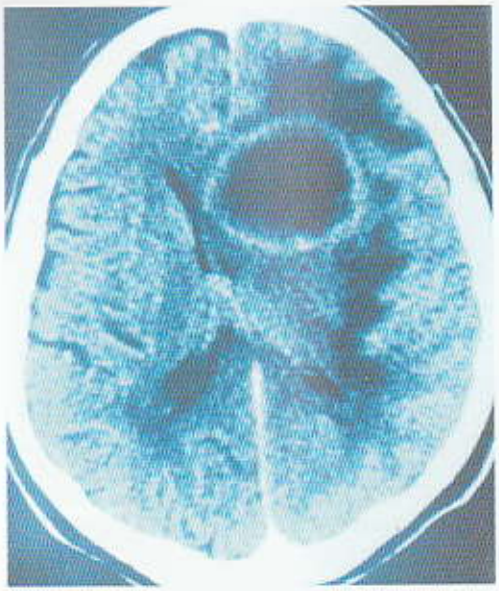


Plate 57:
Tinnitus of the left ear after several relapses; hearing failure and final rupture of the tissue and cyst development in an elderly man in an Austrian nursing home. He could not believe his ears when a fellow patient related horror stories from the war to him.



Plates 58-60:

Plate 58:
Cysts in the right medulla (affecting the right shoulder). A father-child self-devaluation conflict: „I was not fair to my son, I deprived him" Several relapses and definitive resolution through rupture of the brain tissue and cyst development. The cystic shell is scarred over with glial tissue. The finding looks much worse than it actually is.

Plate 59:
Corresponding osteolysis of the left shoulder (father-son shoulder for a right-handed father).

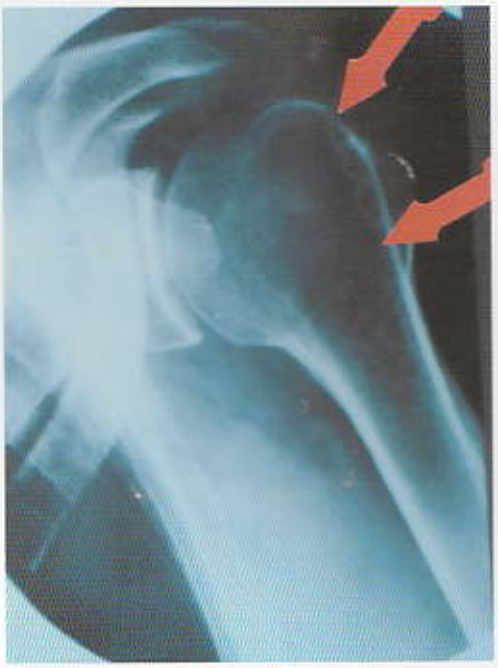


Plate 60:
A higher brain layer of the CT for the same cyst.

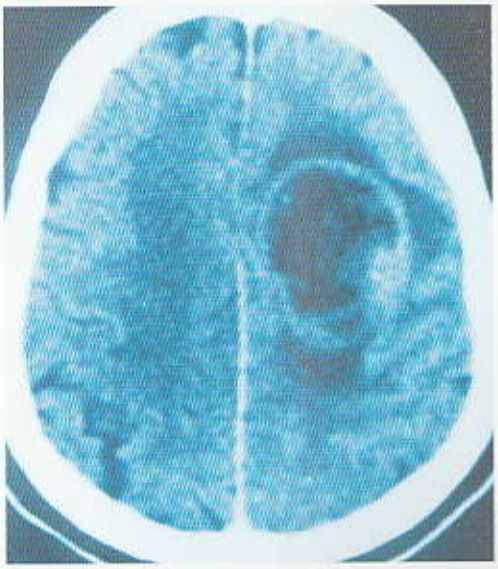
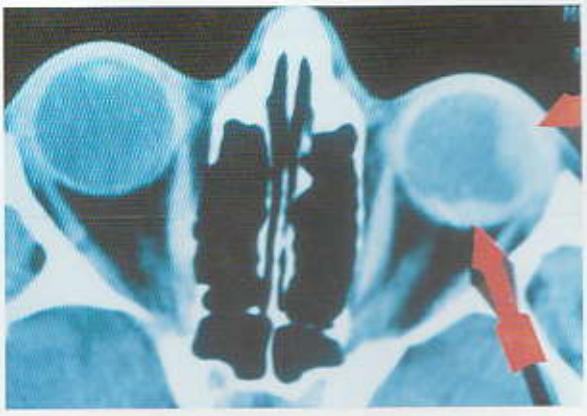


Plate 61:
Old scarred-over retinal detachment in the area of the fovea centralis and laterally in the right eye.



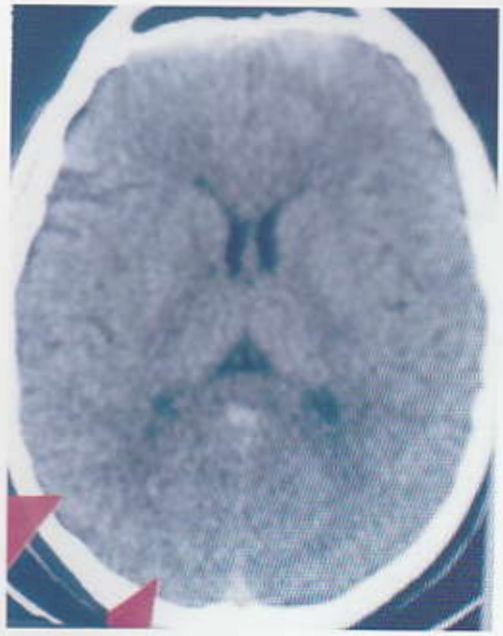


Plate 62:
The corresponding CT shows that the chronically recurring process has by no means come to a conclusion, but that the scarred left visual cortex relay has currently become active (sharp target configuration of the two HH's).

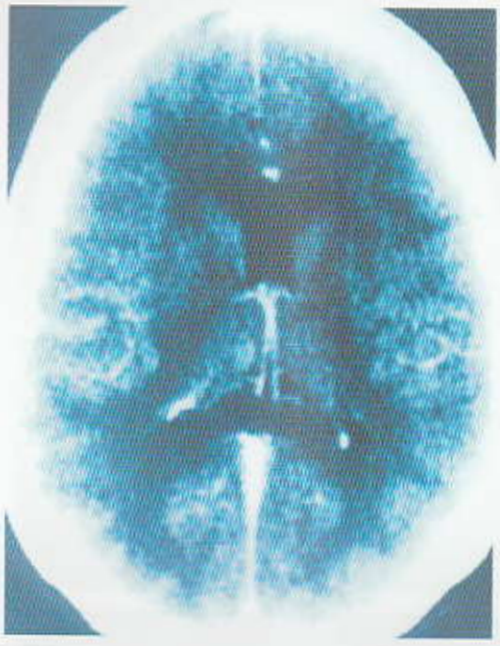


Plate 63:
Two target configurations in the right and left peri-insular areas corresponding to a schizophrenic constellation. In this specific case, a female cult-leader (severely ill) with obsessive after-death thoughts who could not stop dwelling day in day out on the idea that after her death, her good-looking husband would find another woman.

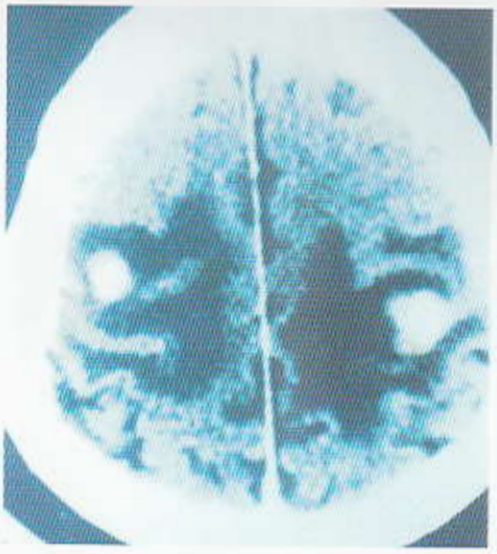


Plate 64:
Condition after schizophrenic constellation. Both HH's in the sensory cortex in resolution.

Plates 65-67: CT's of the brain and lung of an eight-year old boy who had been tied to a tree by his friends as a joke. They had told him they would be back with cannons to shoot him to death. The young boy could not untie himself because his hands were bound. A passerby freed him later that evening.

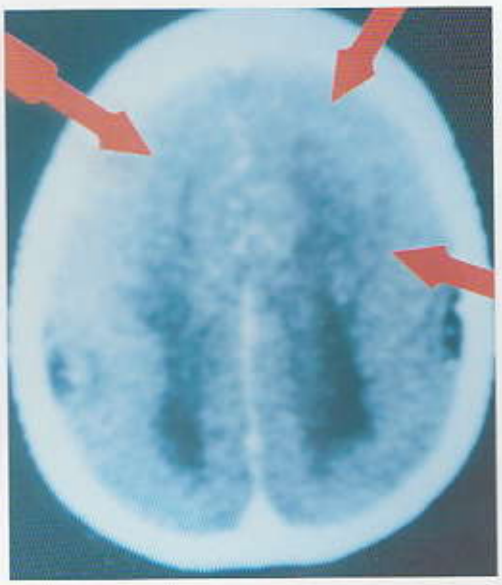


Plate 65:
CT showing a motor paralysis of both arms. We can see the individual target configurations in the motor cortical centre. The young boy's arms were paralyzed for a long time.

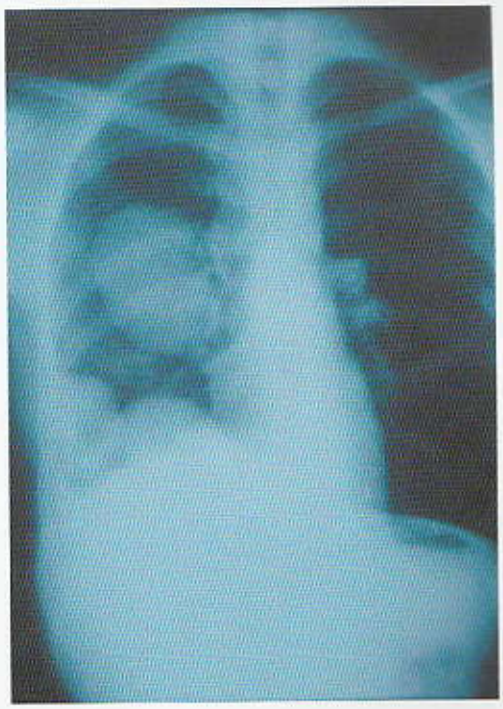


Plate 66:
The lung picture shows a large round lung focus and several smaller ones. The young boy dreamt about the terrible event again and again for several months, suffering fear of death every time. He finally managed to resolve the conflict and died of lung tuberculosis.

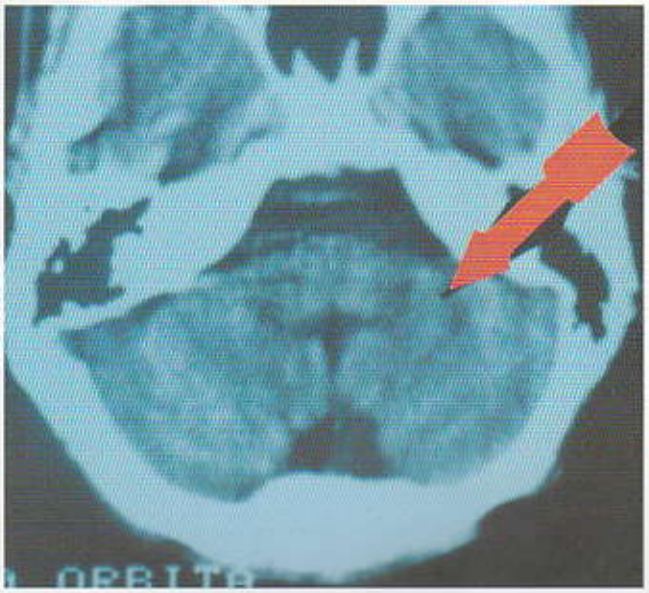


Plate 67:
This CT of the brain stem shows the alveolar relay on the right of the brainstem (arrow) in PCL-phase. The boy had night-sweats for weeks and sub-febrile temperatures and hemoptisis, but he was not treated for tuberculosis because the lung tumor was the main concern of the treatment. With such a pointed diagnosis, it is normal not to think of tuberculosis.

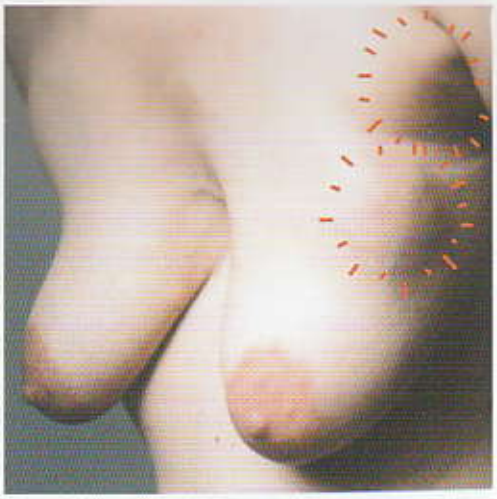


Plate 68:
A young woman with two cell multiplying tumors of the breast glands. The lower tumor of the right-handed woman signifies a daughter mother quarrel conflict. The smaller top one is a mother child concern conflict because of an amniocentesis to prove paternity. She developed an anxiety that this operation would damage the child. In the aftermath, the paternity process continued to roll out on the established 'tracks' even though the child had been born healthy a long time before.

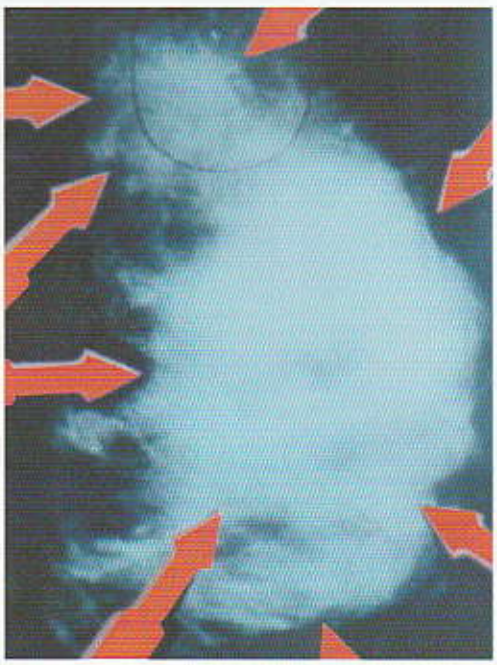


Plate 69:
Mammography of the left breast. The patient had no complications and had more milk in this breast when she nursed than in the right one.

Plate 70:
This CT of the cerebellum shows two overlapping active target configurations in the right lateral area. The two active HH's indicate a mother child conflict, i.e., a daughter mother conflict.

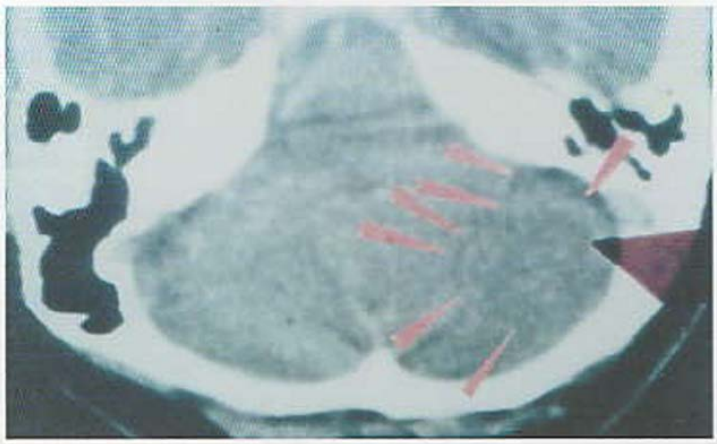


Plate 71:
Several target configurations in the liver: always an early stage of a so-called solitary liver carcinoma. The target configuration in the organ is in correspondence with the target configuration. The exciting element in this empirically discovered relationship is that in fact, the brain and the organ develop target configurations simultaneously, and i.e. we can imagine the nuclei of the cells in the organ all networked, almost like a second brain, an organ brain. The head brain and the organ brain move in the same phase in the same manner, as shown by our target configurations. Instructions go from the head brain to the organ, e.g. motor, or they go from the organ brain to the head, e.g. sensory. These things were partially known from neurology but until now we could go no further because the correlations in the NEW MEDICINE were unknown.

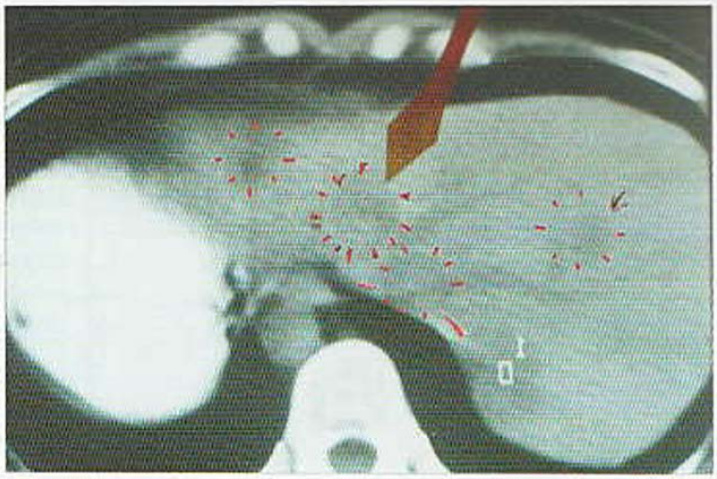
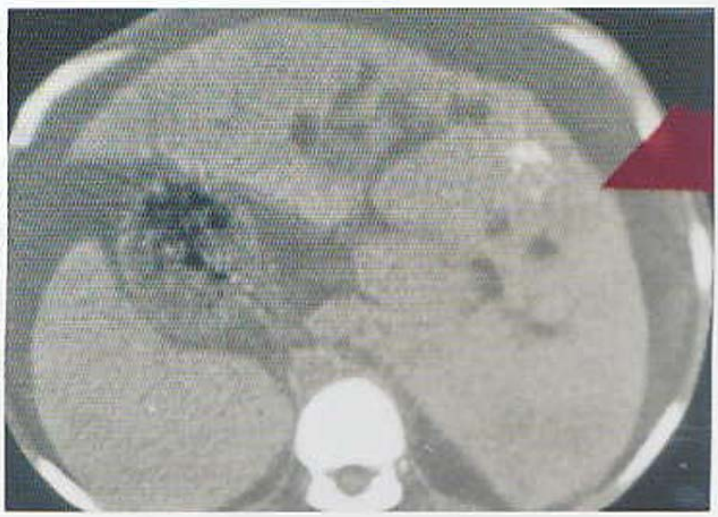


Plate 72 - 74 show the course of such a target configuration in the liver.



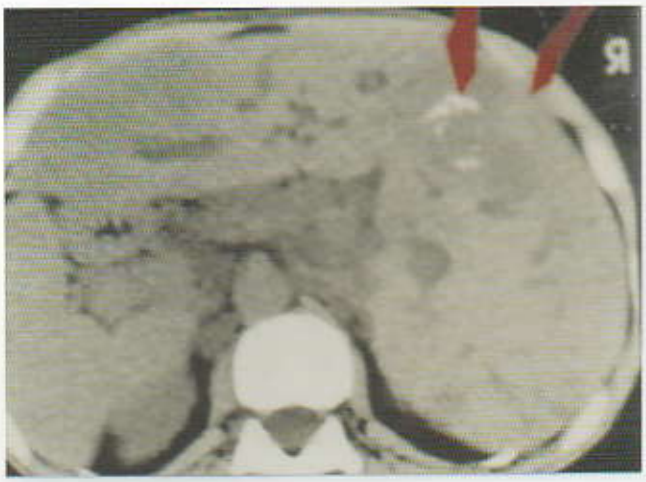


Plate 72 and 73:
show calcified foci, foci that have become active again and again; (plate 73) healing courses, signifying a chronic relapsing process.

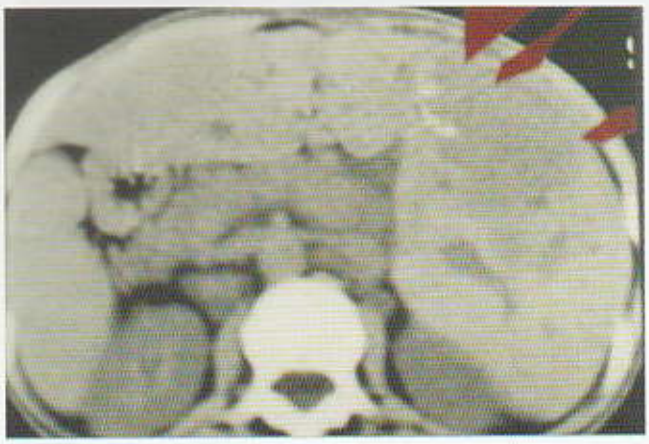


Plate 74:
Renewed healing-phase of the remaining (partially calcified) solitary liver carcinoma as well as the renewal of the process (chronic relapse into fear of starvation). We continue to see the round structure of the 'round liver focus' that results from the original target configuration.

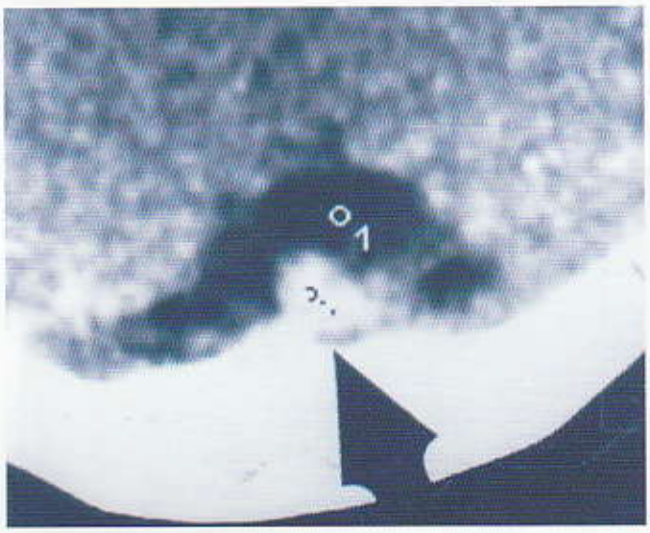


Plate 75:
HH in the PCL phase in the right visual cortex of a young midwife who almost lost a patient in labour through haemorrhaging (cervical tear). She suffered 'fear from behind' from then on because it might happen to another woman in labour. The conflict was resolved after she left the labour department. Vision in her left eye had worsened in the CA-phase; a retinal detachment during the PCL-phase followed the usual short-lived dramatic aggravation as a symptom of healing.

Plate 76:
Conflict activity of an HH in the left peri-insular temporal area. Conflict: after a wonderful night of lovemaking, wife told by her husband that it had not been that important. The patient suffered a sexual frustration conflict and showed a confirmed carcinoma of the cervix as well as an ulceration of the coronary veins. She resolved the conflict by separating from her husband and survived the epileptoid crisis of the pulmonary embolism. Three months later, a smear of the cervix was negative.

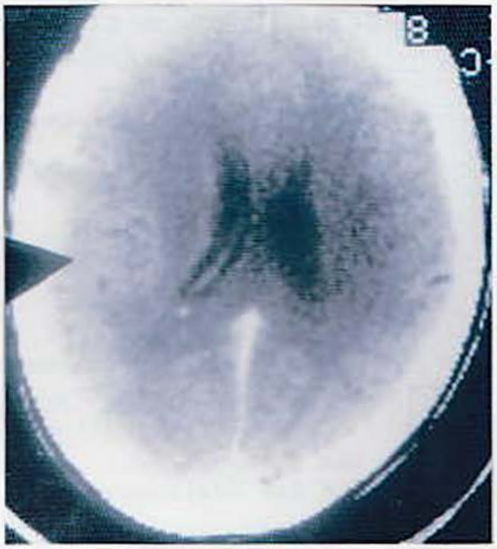


Plate 77:
HH in the PCL-phase of a carcinoma of the cervix and ulceration of the coronary veins immediately before the infarction of the right side of the heart and consequent lung embolism: the conflict: the patient's boyfriend made her best friend pregnant. Duration of the conflict was seven months. The CL came through the reconciliation of the two friends. The patient survived both the cervical carcinoma and the so-called brain tumor without any standard medical therapy. The highly dramatic epileptoid crisis (heart and lung infarction) was controlled with high doses of cortisone.

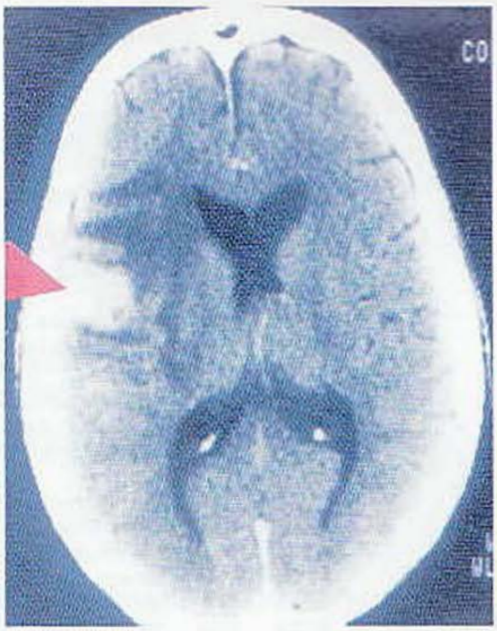
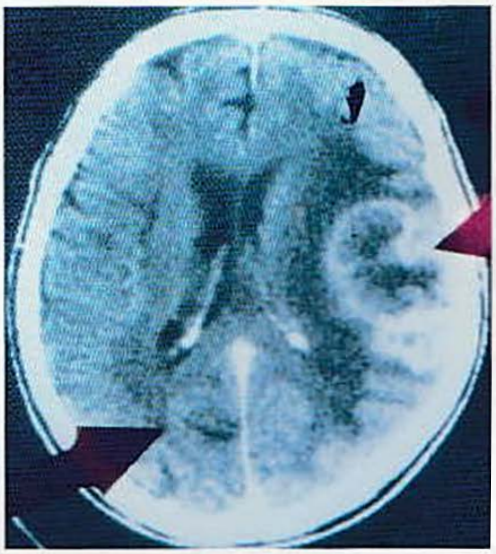


Plate 78:
HH with territorial conflict for a right-handed man in the PCL-phase after left heart infarction (swelling of the ulcerated coronary arteries). The conflict: the farmer's only son suffered an apparently fatal accident and was interned in the intensive care unit. The farmer suffered both a territorial conflict because he thought he no longer had an heir for his farm, and a loss conflict as a father. He suffered a left heart infarction and a swelling of the right testicle in the PCL-phase (the son lived). The patient survived with no standard medical therapy.



Erlangen, 22.12.89

Sog. fragliche Ringstrukturen/Artefakte im Hirn-CT

Die Unterzeichner haben folgende 8 Ausschlußkriterien erarbeitet, die das Vorliegen von sog. Ringartefakten ausschließen.

Ein Ringartefekt liegt demzufolge sicher nicht vor,

1. wenn im NMR eine vergleichbare eindeutige Ringformation sichtbar ist,

2. wenn die Ringe nicht rund, sondern "eingedellt" sind, d.h. offensichtlich Raumforderungen miteinhergehen,

3. wenn eine Kreisformation offensichtlich Gliaeinlagerungen hat,

4. wenn der oder die Ringe nicht im Dreh-Zentrum der Anlage liegen ("parazentrale Schießscheibenkonfiguration"),

5. wenn mehrere Kreise gleichzeitig nebeneinander bestehen, kann höchstens 1 Ringformation Ringartefakt sein,

6. wenn die Ringformationen einen klinisch-radiologischen "Verlauf" haben, d.h. daß sie auf nachfolgenden Kontroll-CTs wieder an gleicher Stelle, aber verändert sichtbar sind.

7. Die gerägeabhängigen Artefakte sind kreisförige oder kreissegmentförmige Strukturen um das Drehzentrum der Anlage. Wenn solche Strukturen echten anatomischen Gegebenheiten entsprechen können, empfiehlt sich die Wiederholung des Scans mit seitlich oder in der Höhe verschobener Patientenposition. Wenn die Struktur in dem wiederholten Tomogramm bezüglich markanter, patienteneigener Strukturen nicht verschoben ist, liegt kein Artefakt vor.

Siemens Aktiengesellschaft
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Henkestraße 127 - Telefon (09131) 840
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8520 Erlangen

Proposal for a common protocol for a further planned study of a series of CT's of volunteer patients with round structures in their brain CT's (see text) which was vetoed.

SIEMENS

Erlangen, 18.05.90

Betrifft: sog. Ringstrukturen, Rundformationen, Schießscheiben-Formationen oder HAMERsche HERDE im Hirn-CT

Die Fa. Siemens und Herr Dr. Hamer bestätigen folgende physikalisch-technische Zusammenhänge:

Die Unterzeichner haben schon am 22.12.89 folgende 8 Ausschluß-kriterien erarbeitet, die das Vorliegen von sog. Ringartefakten ausschließen:

Ein Ringartefakt liegt demzufolge sicher nicht vor,

1. wenn im NMR eine vergleichbare eindeutige Ringformation sichtbar ist,

2. wenn die Ringe nicht rund, sondern "eingedellt" sind, d.h. offensichtlich Raumforderungen miteinhergehen,

3. wenn ein Kreis ganz offensichtlich oedematisierte Ring-Begleit-erscheinungen hat ("Oedem-Ringe")

4. wenn der oder die Ringe nicht im Dreh-Zentrum der Anlage liegen ("parazentrale Schießscheibenkonfiguration")

5. wenn eine Kreisformation offensichtlich Gliaeinlagerungen hat,

6. wenn mehrere Kreise gleichzeitig nebeneinander bestehen, könnte höchstens 1 Ringformation sog. "Ringartefakt" sein,

7. wenn die Ringformationen einen klinisch-radiologischen "Verlauf" haben, d.h. daß sie auf nachfolgenden Kontroll-CTs wieder an gleicher Stelle, aber verändert sichtbar sind.

8. Es liegt auch kein Artefakt vor, wenn die Rundformationen nur auf einem Teil der CT-Schichten sichtbar sind, auf anderen aber fehlen.

9. Die geräteabhängigen sog. "Artefakte" sind kreisförmige oder kreissegmentförmige Strukturen um das Drehzentrum der Anlage. Wenn solche Strukturen echten anatomischen Gegebenheiten entsprechen können, empfiehlt sich die Wiederholung des Scans mit seitlich oder in der Höhe verschobener Patientenposition. Wenn die Struktur in dem wiederholten Tomogramm bezüglich markanter, patienteneigener Strukturen nicht verschoben ist, liegt kein Artefakt vor.

Erlangen, 22.17. 89

So-called dubious ring-structures/ artifacts in CT's of the brain.

The undersigned have elaborated the following eight exclusion criteria to eliminate the possibility of ring artifacts:

The following preclude the possibility of a ring artifact:

1. If there is a similar ring formation clearly visible in the MRI.
2. If the rings are not round but dented, i.e. there are obvious masses at the same time.
3. If there are deposits of glial tissue in the circular formation.
4. If one or more rings are not centred on the pivotal centre of the shot (para-central target configuration).
5. If there are more circles simultaneously adjacent to each other, only one of the ring formations at most could be one ring artefact.
6. If the ring formations have a clinical radiological 'course', i.e. the sequential follow-up CT's show them at the same locations but changed.
7. Those artifacts generated by the installation are structures that are circular or in the form of a circular segment centred on the pivotal centre of the shot. If such structures could possibly represent real anatomical structures, a re-take of the picture is advisable with a lateral or vertical displacement of the patient position. If the repeated tomography clearly shows the structures without relative displacement, then these are not artifacts.

Siemens Corporation
Medical Technical Division
Address and signatures

SIEMENS

Erlangen, 18.05.90

Subject: so-called ring-structures, round-formations, target formations or Hamerschenherd in brain CT's.

The firm Siemens and Dr. Hamer verify the following physical technical relationships:

The undersigned, on the 22.12.89, have already articulated the following eight exclusion criteria to eliminate the possibility of ring artifacts.

The following preclude the possibility of a ring artefact:

1. If there is a similar ring formation clearly visible in the MRI
2. If the rings are not round but dented, i.e. there are obvious masses at the same time
3. If there are deposits of glial tissue in the circular formation
4. If one or more rings are not centred on the pivotal centre of the shot (para-central target configuration)
5. If there are more circles simultaneously adjacent to each other, only one of the ring formations at most could be a ring artefact
6. If the ring formations have a clinical radiological 'course', i.e. the sequential follow-up CT's show them at the same locations but changed
7. Those artifacts generated by the installation are structures that are circular or in the form of a circular segment centred on the pivotal centre of the shot. If such structures could possibly represent real anatomical structures, a re-take of the picture is advisable with a lateral or vertical displacement of the patient position. If the repeated tomography clearly shows the structures without relative displacement, then these are not artifacts.

14 Therapy in the NEW MEDICINE

14.1 The normal course and the unusual course of a so-called disease

14.1.1 With conflict resolution

It is normal for a disease to have a DHS. It is a biological law that a sympathicotonic phase follows the DHS. From then on, several things can normally occur in accordance with certain principles.

1. If there is conflict resolution (CL), the illness will be two-phased, i.e. there will be a vagotonic healing phase after the resolution.

14.1.2 Without conflict resolution

2. If there is no resolution, but ongoing (hanging) conflict activity, there are two further possibilities:
   a) if conflict activity is acute, the disease may be mortal and will end in cachexia;
   b) the organism manages to reduce the severity of the conflict (hanging conflict activity), i.e. the organism has accommodated itself to the conflict, conflict activity remains, but it has been lowered and is less intense. Mother Nature can generally handle such downgraded conflict activities -hanging active conflicts - as social programs for a group, pack, herd or family.
3. The conflict may recur, which again allows for two possibilities:

a) predominant conflict activity, resolved by small or short healing phases. We then speak of a chronically recurring conflict activity.

b) the conflict is continuously in resolution but does not end because there is always a small recurrence before each resolution. In this case, we call it a 'hanging healing', which corresponds to a chronically recurring conflict, with the difference that the timing is not the same. There is ongoing healing interrupted by short conflict recurrences. An example is Parkinson's disease. The Parkinson-tremor, which is a form of healing, is more precisely the healing of a motor conflict of the musculature of the hand. The patient dreams his conflict every night, short but intensely. The healing involves maybe 23 hours and 58 minutes and the conflict recurrence lasts only 2 minutes. However, in spite of this, the conflict never ends.

Of course, there are combinations of these possible developments. For example, healing with only one recurrence, or a conflict activity that was once fully resolved and lasted only a short time. There are also hanging-active conflicts that suddenly turn into chronically relapsing conflicts or hanging healing ones. It all depends on the psychological ups and downs in the soul of the patient.

14.1.3 Combinations of different conflicts = 'Syndromes'

Variations occur not only within conflicts or conflict-events, but also when several simultaneous conflicts or conflicts co-exist at different points in their phases.

As well, there may be two or three conflicts all hitting the same brain hemisphere at the same time from the same DHS but at different points, corresponding to different conflict

aspects. It is also possible to have two simultaneous active conflicts that are not resolved at the same time. Consequently, one is in conflict activity and the other is in resolution. This results in a mixed innervation - half sympathicotonic, half vagotonic - by no means leading to normalcy but, on the contrary, leading to further complications.

If a female patient has a fear-revulsion conflict in the left glucose centre with another active conflict in the right cortical cerebral hemisphere that has just gone into resolution, she has continuing hypoglycaemia together with vagotony. This means she will eat inordinate amounts of food and become obese. To put it in a different way, the woman in question is in a schizophrenic constellation with cortical conflicts (see chapter on diseases of the mind and spirit).

Another example is so-called pernicious anaemia, a clinical picture described in every textbook. We were familiar with the second stage of the first component, namely, the lack of intrinsic factor in the case of stomach ulcers or gastritis; we just didn't know what caused gastritis.

We also did not know the cause for anaemia, the second component. The lack of intrinsic factor is substituted with Vitamin B12. We now know both causes:

1. The patient has a self-devaluation conflict in the CA-phase.
2. The patient has a territorial-anger conflict with stomach ulcers and gastritis also in the CA-phase and therefore unable to produce the intrinsic factor.

The combination of both these components, i.e. a mesodermal cerebral medulla-directed conflict and an ectodermal cortex-directed conflict (it does not seem to matter whether they are one-sided or contra-lateral). This unusual combination results in pernicious anaemia.
Even though we know how to therapeutically cure the pernicious anaemia by resolving both conflicts, no one prevents us from occasionally injecting the patient with Vitamin B12.

A further example:
Every textbook describes the nephrotic syndrome, the symptoms of which are: proteinuria, hypo and dysproteinemia, hyperlipidemia, accelerated erythrocyte sedimentation rate and eventually generalized edema. The supposed cause is thought to be the altered permeability of the basal membranes of the glomerules, both for inflammatory as well as for degenerative kidney diseases.

The NEW MEDICINE clarifies the cause of this syndrome: the case is tuberculosis of the cancerous collecting tubules of the kidney; that is, a healing phase of carcinoma of the collecting tubules. The corresponding conflict is a refugee or existence conflict.

By its very nature, this existence conflict and the healing phases recur frequently, which is why the nephrotic syndrome is considered chronic.

Patients formerly died of the hypo and dysproteinemia, while the kidney function, with respect to the components usually eliminated with the urine, remained intact. The albuminuria explains itself in this way: just as the tubercular caseation of a breast tumor creates a great deal of wound secretion, so the renal pelvis does during the caseation of a collecting tube carcinoma. The method of choice is to substitute the hypo-proteinemia with albumin infusions and to continue until the healing phase has reached its conclusion. This is in the assumption that no new recurrences with subsequent PCL phases or a renewed nephrotic syndrome will occur. (cf. two cases in the 'Celler Documentation').

We could, of course, describe the most diverse syndromes through the NEW MEDICINE, but that is beyond the scope of this thesis.

14.2 Working with the biological laws

To apply the NEW MEDICINE in a practical way, we must distinguish between what is optimally provided through this system and what is feasible, given today's social and medical conditions.

After the patient has given a thorough account of his medical history that must include the circumstances of his life, his environment and his social setting, the doctor should be in a position to consider the complaints or the findings already available and prepare a conflict anamnesis. For a physician practising the NEW MEDICINE, all information, whether human or medical, is of the greatest interest because there is always a set of brain scars that cannot be explained without this information. The most important point is to establish the DHS, to discern its precise point in time and the accompanying circumstances. Where possible, there should be a brain CT available by the first full examination, assuming a non-invasive investigation. The CT is vital for the conflict anamnesis because it allows focused questioning to establish the nature of the conflict contents that are already indicated in the pictures.

For an evaluation, a CT in standard layers should be obtained; the radiation dose is minimal. Substituting a Magnetic Resonance Image (MRI) for a CT is inappropriate in the NEW MEDICINE. The examination lasts significantly longer, is physically very taxing and its effects on the organs are not well known. It has the added disadvantage of not showing the sharp ringed target configurations because it is focussed on water molecules. However, in the PCL-phase, an MRI is helpful, as it shows accumulations of glia and edema very clearly but, for a professional, a CT does this just as well. The nuclear spin imaging technique shows organic and cerebral changes too dramatically from an optical point of view and the patient can be left with an impression that he has a gigantic tumor, whereas the CT appears substantially much less impressive.

The individual steps required to trace the development of a disease are described in detail in the chapter on methodology. We are also aware of the various possible combinations and variations. We would like to address a list of practical questions. At this point, optimal biological therapy should step aside in favour of practical questions that the patient is eager to ask. Within NEW MEDICINE, a patient with intestinal cancer would be advised to put up with the least possible intervention while tuberculosis bacteria mediate the CL. However, this would collide with today's rules and regulations; so it would not be very useful for the patient to know what he could optimally do if he is not allowed to do it.

14.2.1 Calculation of the development of the conflict from the DHS on

Rash diagnoses or prognoses should not be made without knowing the duration and intensity of the conflict activity, that is, without knowing the mass of the conflict and without being clear whether it is feasible for the conflict or conflicts to be resolved. Many conflicts seem to be easily resolvable in theory but are not so in practice because the patient is constrained. He cannot give up his job, cannot sell his company, cannot divorce, cannot avoid his mother-in-law, etc. If a feasible resolution cannot be achieved in practice, an effort must be made to find a second or third-best or even a purely intellectual resolution that includes everyone involved in the conflict - relatives, friends (even employers, bank, authorities, etc). Only then will there be a point of reference for a later prognosis. Attempts should be made to steer conflicts to a solution together with the patient. There will be discussion later in this chapter on where a conflict resolution should be attempted.

14.2.2 What awaits us on the cerebral and organic planes?

The NEW MEDICINE is not a partial discipline that is confined to the conflictolysis but delegates complications to other partial disciplines. On the contrary, it is an all-encompassing medicine that considers all the steps in disease development, including the cerebral-organic plane. This includes the need to be able to estimate, from the process that has taken place so far, how long the healing will take and what dangers and complications can be expected on the cerebral and organic planes. This is not the place to list all the possible complications; that is where the experience and knowledge of a clinician counts most.

In the same way that he would help himself, a good physician should use all the medical means at his disposal in the way of drugs and surgery to help his patient. In NEW MEDICINE, we have the responsibility to assist the patient through the PCL-phase inasmuch as there can be a conflict resolution. The PCL-phase holds far greater difficulties for the physician than the CA-phase. He has to convince the patient that his current symptoms are not as bad as they appear, and should actually be welcomed. There are, however, real medical crises that sometimes have to be endured. Consider, for example, cases such as the first phase of leukaemic healing, or the epileptic/epileptoid crisis that, even if identified, were known under other labels, i.e. misunderstood. We build on the basis of symptomatic therapeutic relief that we have always had, for example, to reduce the severity of a vagotonic phase. However, with our new understanding of microbes everything must be re-thought. It is therefore no longer possible to recommend doses according to standard practice. This is especially true for cortisone therapy, which we know can cause edema to regress, particularly in the brain.

14.2.3 The medication

It is important to note that in order to helpfully support the healing process, all medications that can alleviate symptoms should be considered.

It was believed that medication worked either centrally or peripherally. However, with the knowledge of the NEW MEDICINE, this becomes relevant because in practice all medications work centrally, i.e. from the brain to the organ. Whereas we formerly believed that the action of digitalis was to saturate the heart muscle, we now understand that it acts cerebrally on the heart brain relay.

The physician in the NEW MEDICINE is not opposed to medication even though he understands that Mother Nature has already optimized all developments. He knows that most cases do not need the support of medication therapy because the conflicts are of short duration, resulting in smaller conflict mass and a healing phase that does not entail special complications. What remains are the cases in nature that would come to a lethal end and which involve a special approach from a medical ethics point of view.

The most critical points in the healing process for certain conflicts and diseases are, for example, the EC (epileptic crisis) for left and right heart infarction, pneumonic lysis (fever), the hepatic crisis, etc. These crises still result in death in a large percentage of cases. In future, we will still lose many patients, but we now have the advantage of knowing from the start what to expect and to be prepared for the developments as they approach. It is not much use to have reduced the frequency of pneumonia by renaming it 'bronchial carcinoma' (see chapter on statistics) if the patients die of an actual bronchial carcinoma; we have really only renamed the disease. If we know exactly when to expect the pneumonic lysis and know what has to be done to influence this normal biological development in a beneficial manner through antibiotics and cortisone, then we have a

completely new departure point in the NEW MEDICINE. Even if the means are the same, our understanding is completely different.

Example:
If we know that the conflict (territorial fear) accompanying pneumonia lasted only three months, we know that the pneumonic lysis (EC) is not likely to be lethal, even without medication. The patient is calm because the physician conveys assurance.

If the conflict has lasted for nine months or longer, the doctor knows that, if nothing is done, the EC of the pneumonic lysis will be a question of life and death. He must prepare himself and his patient to mobilize all the patient's strength and to exhaust all medicinal possibilities: in a special case like this, that would include not only antibiotics (as in the past), but also massive doses of cortisone (not done in the past) which should be administered while the epileptic crisis is in progress in order to overcome the critical point that always occurs after the EC. This critical point exists so that after the EC, a lasting vagotonia sets in which does not take the patient into deep vagotony, but pulls him out of it. The organism has programmed the EC for this change, of course, and its resources are enough in 90% of cases. The remaining 10% would inevitably die in nature - in this particularly severe case - from respiratory failure because of the insufficient EC (epileptic crisis) in vagotonic cerebral coma (cerebral edema).

Another example:
We understand the precise origin of the nephrotic syndrome with the help of the NEW MEDICINE: namely, the PCL-phase of a collecting tubule carcinoma, and loss of protein through a wound exudates in the area of the tuberculous caseation process. We also know now what we have to do (see case in the 'Celler Documentation'): if, for some reason, the patient is not capable of replacing his protein loss by oral protein absorption, albumin should be injected to supplement the hypoalbuminemia, until the healing process is completed.

With the PCL-phase of a peritoneal carcinoma, we can prepare the patient for the ascites as soon as he resolves his conflict (attack against the abdomen). The patient can welcome the ascites as a good occurrence. If he has tubercular bacteria, he will have the obligatory night sweats and sub-febrile temperature - something he adjusts himself to and considers a problem to be overcome.

14.2.3.1 A word about cytostatic chemotherapy

I believe this to be a dangerous symptomatic pseudo-therapy, possible only because the laws of the NEW MEDICINE were not known. Chemotherapy is apparently successful (at the cost of the bone marrow) in that it suppresses the symptoms of the healing phase for cerebrally directed organs. This is bought at the price of several critical effects, one of which is the necessity to continue its use in order to prevent a recurrence of the healing symptoms, ultimately leading to a pthisis of the bone marrow and certain death.

Another, even worse danger is that the rounds of chemo regress the brain swelling and provoke a dangerous accordion effect. Chemotherapy, as much as radiotherapy, radically lowers the synaptic elasticity of the brain cells. These cells rupture and can lead to the cytostatic mediated apoplectic brain death of the patient.

14.2.3.2 A word about pain and morphine

A 'malignant' diagnosis given by a hystologist permits a physician to administer morphine to the patient at the least intimation of pain. The side effects of the morphine -addiction, respiratory suppression, and intestinal paralysis - are accepted without hesitation.

Morphine has therefore always been a one-way street - death by advice. It is a tragic fact that pain occurs in the healing phase, and that it is usually limited in duration. Such is the case in bone osteolysis in the PCL-phase. It results in acute periosteum pain, regarded as the most feared pain in medicine. With the NEW MEDICINE, we can precisely identify the stage of the disease the pain corresponds to, its quality, its duration, etc. I have never known a patient who wanted the morphine, even if offered, once he was told the bone pain would last 6 to 8 weeks after which time his bone would be healed. The patient mentally prepares himself and we can help him by distracting him with things like theatre, comedies, light films, singing, swimming, and, for the external pain, with therapies like acupuncture, massage, etc. This works nearly every time.

It is important to know that morphine immediately creates very serious mental and cerebral changes that quickly destroy the patient's morale so that he is unable to withstand any pain from that point on. Since pain is something subjective, patients experience a severe increase of pain intensity as an after-effect of the morphine, as if they had never taken morphine at all. It is recognized that the dose has to be continuously increased. The patient dies a morphine death - the intestine becomes inactive and he dies of hunger and thirst.

14.2.4 Exploratory punctions and exploratory excisions

The knowledge that the same place in the organ will always be affected with the same histological formations, even in the case of cancer, drastically reduces the need for exploratory punctions and exploratory excisions. Our experience shows that a CT can give us more precise information than an exploratory punction.

An exploratory excision of bone sarcoma is almost always the beginning of a catastrophe because the callus fluid contained under pressure finds a way out through the open periosteum (bursting of the periosteum seam) into the surrounding tissue and leads to a gigantic sarcoma. If the exploratory punction had not been performed, the surrounding tissue would only have swollen somewhat, because the fluid flows out of the periosteum, but not the callus cells. The process would have been similar to acute joint rheumatism that has spontaneous remission after a certain amount of time.

A punction can have fatal consequences in the case of a so-called cold abscess - i.e. a carcinoma of the breast gland in the PCL-phase - where the puncture biopsy of the breast creates an external opening. This leads to a foul-smelling tuberculous discharge from the breast. As with the opened osteolysis in its healing phase that can only be stopped from continual formation of callus fluid by chemotherapy and eventual amputation, so the outcome in the case of the punctured breast will be a quick amputation.
For this reason, exploratory punctions and exploratory excisions will be performed only on very rare occasions in the future.

14.2.5 Surgical interventions

At present, most operations are so-called cancer operations. The surgeon is governed by the histologist's sentence that declares either a benign or a malignant process. However, we know that all cerebral medulla directed necroses in the healing phase make so-called malignant tumors (lymphomas, osteosarcomas, kidney cysts, ovarian cysts), but the NEW MEDICINE sees them all as 'healing tumors', i.e. harmless cell multiplication only to be operated on if they create mechanical interference or if they are unacceptable to the patient emotionally. We still need the surgeon in cases of old brain directed tumors just as we need the hunter in the forest since we no longer have wolves: with this, it is important to

differentiate exactly how big the intestinal tumor is when it comes to conflict resolution. If the tumor is relatively small, we can assume, even if there are no tubercular bacteria, that there will be no serious complications. However, if the tumor is large and capable of making an intestinal obstruction, we must very carefully consider whether to wait out the healing phase in the hope that tuberculosis will take over the healing process quickly. In any event, the patient must be warned that this constitutes a risk just as an operation would. It is better to operate during the patient's CA-phase because during the PCL-phase the anaesthesia, combined with the vagotonia, presents a much greater risk. Always emphasize to the patient that he is the key decision-maker, and very carefully explain the pros and cons.

The NEW MEDICINE also has some surgical indications of a negative kind. For instance, ovarian-and kidney cysts develop at approximately the rhythm of a pregnancy and require nine months to become indurated and take over the function designed for them by the organism. There should be no operation in these nine months because during this time the cysts, lacking an arterial and venous system, attach themselves to other abdominal organs to provide themselves with a blood supply. This biological process has been misinterpreted as 'malignant infiltrating tumor growth'. The evidence was self-fulfilling since the tumor portions kept growing for nine months and needed to be operated on repeatedly, seeming to be uncommonly malignant. These premature operations, because of official medicine's lack of understanding, usually extirpated the affected organs as well, with the consequence that the abdomen became little more than a torso. We will not even discuss the consequent conflicts of these poor patients. Instead, if one waits out the nine months, it will not even be necessary to operate small cysts of less than 12 cm since they fulfill the function of hormone production, specifically the elimination of urine as foreseen by the organism. An operation would be indicated only in extreme cases where the cysts bring about serious mechanical problems, and after approximately nine months and induration of the cyst. Such an operation is technically a small intervention because all adhesions have been released in the meantime and the cyst is encased in a tough capsule. (See case examples in the Gelsenkirchener and Celler Documentation).

14.2.6 Psychagogic care of the Patients

The goal of every therapy must be to promote an understanding of the inter-connections of the patient's disease. For a patient who is always alone and in constant danger of panic brought on by his surroundings, it will be very difficult to defend himself while the NEW MEDICINE remains an 'outsider-medicine'. In a good clinic where all colleagues and patients understand the NEW MEDICINE, this panic making would not exist. Such an enclosed therapeutic space would allow patients to trust their therapists, who are not necessarily doctors, who can explain to them their current symptoms and those that are to come. This also requires patients to be isolated for a while in order to prevent conflict relapses. I am thinking here of a symbolic 'fortress', offering protection from banks, creditors, lawyers, employers, vengeful wives, mothers-in-law, offspring or relatives keen on an inheritance. In short, all the dangers of a conflict relapse.

For the patients who do not make it in the end but who are full of hope, death without morphine or intensive care is more humane and natural, a passing over into another world, not an end filled with mortal fear and panic. Such a death, for the patient and the family, is a dignified leave-taking.

14.3 Biological planning of life-long conflicts (second-wolf phenomenon)

We have already discussed the fact that biological conflicts are something very meaningful, especially at the organic level. These connections were not seen because we were blind to the biological aspects of evolutionary history in connection, for example, with tumors. We will consider the conflicts that Mother Nature elevated to be long-term-systems and consequently planned for them in the brain. By this I mean that there is meaning to be found in a situation such as when a man suffers a territorial conflict, for example, and cannot resolve it during his lifetime. The meaning is even clearer with an animal in the same situation.

We are at the very beginning of understanding in this field and must learn from cultural anthropology and from the studies being done on behaviour and primates. Scientists who only collect facts, ask the wrong questions and observe many phenomena very superficially, end up no further than where they started.

Our performance-oriented society has a tendency to judge and evaluate people, especially men, in terms of masculine criteria which are: position and standing at work, ability to assert oneself in one's career, a certain amount of disrespect, hierarchical thinking, marriage to a woman, establishment of a family, etc. These are criteria that not all men can meet and that usually underlie their hanging conflicts.

As already mentioned, an individual has a specific amount of time to resolve a (territorial) conflict. If a resolution is not reached, the possibility remains of downgrading the conflict in order to guarantee survival with a hanging conflict. A right-handed man would be quasi-blocked on the right brain hemisphere with a territorial conflict and would react to a further conflict on the left 'female' side. This clearly has obvious consequences in daily life. Such a man must fulfill entirely different duties in order to be able to co-exist within the context of his group, and the usual criteria used for measuring the achievements of men would no longer apply to him.

Let us observe a pack of wolves: we establish that there is only one male and one female leader; and the rest of the male animals in the pack are young wolves or second-wolves. Second-wolves resemble the leader but are actually quite different; they may not carry their tail as high, they may not lift their leg but will urinate like females and they have no role in procreation. This suggests that these wolves have suffered a territorial conflict as a consequence of a serious territorial fight, the conflict remaining hanging. They virtually react in a female way. Such second-wolves may never become free of these hanging conflicts because their lives probably depend on them. If a second-wolf were to resolve its territorial conflict, it would die shortly after from a heart attack and that is not nature's intention, as it would not help the individual or the pack. The second-wolf is changed for life and receives constant reminders from the leader about its rank. This constellation is ideal at the same time for the pack, because if there were constant territorial fights, the pack would be incapable of functioning.

Such comparisons, of course, are risky. My wish at this point is to sharpen everyone's vision of the biological function and the biological meaning of life-long hanging conflicts. They seem to have a double function, for the individual and the group.

14.4 Mental illnesses and mood disorders - temporary survival possibilities towards later resolution. The so-called developmental retardation

The NEW MEDICINE began in 1981 with the connections between the origin and development of the so-called cancer diseases being condensed in the 1984 pocketbook '*Cancer, Disease Of The Soul, Short-Circuit In The Brain, The Computer In Our Organism*' which includes my findings on heart infarctions, i.e. left heart infarctions and right heart infarctions (which are also called lung embolisms).

As early as 1987, '*Legacy of a NEW MEDICINE*' Volume 1 stated that all so-called diseases or special programs of the organism take place according to the four biological laws of the NEW MEDICINE. These special programs also include mental illnesses and mood disorders that, to date, have been considered disorders of the mind without an organic reference. This was mistaken, for so-called mental illnesses and mood disorders develop exactly according to the five biological laws of the NEW MEDICINE. They all have a brain correlate and an organic correlate - to be precise, two brain and two organ correlates - and proceed by additional rules which may in future be seen as laws, but which, for now, I designate as rules.

14.4.1 Depression

The rule for depression: depressions affect left-handed women with a sexual conflict; shock-fear conflict or identity conflict; a male or female who is in hormonal imbalance with a territorial conflict (the balance between male and female hormones is almost even but leans slightly to the male side); territorial fear conflict; territorial marking conflict (i.e. with a conflict in the right territorial area) in the right temporal lobe.

14.4.2 Mania

Mania automatically affects a left-handed male with a territorial-conflict, territorial fear-, territorial anger- or territorial marking conflict because he suffers the HH on his left, as a left-hander rather than on the right territory side. Another situation involves a patient in hormonal imbalance but leaning slightly to the female side; the patient suffers from a female sexual conflict, shock-fear conflict, identity conflict or inner territorial marking conflict.

14.4.3 Schizophrenic cerebral hemisphere constellation

There are two necessary criteria for the schizophrenic constellation:

1. The entire brain is not functioning in normal rhythm.
2. The two brain hemispheres function in different rhythms.

These two conditions can be brought about by the following HH's:
Suffering a central conflict that affects both hemispheres equally. This prevents the entire brain from functioning in normal rhythm. Should there be another cortical conflict, no matter on which side, then each brain hemisphere functions in a different rhythm. This fulfills both conditions. I cannot define the concept of 'normal rhythm' in a scientifically satisfactory manner at this time. Thus far it is empirically sound. One must imagine a rhythm that has not been altered or impaired by externally influenced conflict activity (e.g. chemical) such as brain damage, drugs, or alcohol. This also represents the natural healing of the HH, with the following restoration of the 'normal rhythm'. Both these conditions are

also fulfilled if the patient suffers active cortical foci both on the right and the left. It is then that both hemispheres vibrate differently from each other, i.e., no longer in the normal rhythm. Thus, if these two conditions exist and the patient has corresponding cortical foci in conflict activity, he is then in a schizophrenic constellation. There are however, two other possibilities for being in schizophrenic constellation.

1. Drugs automatically alter the brain's normal rhythm; this, then, has already brought about the first condition. Just one existing or one new conflict puts the patient into schizophrenic constellation immediately. This explains how people with an active cortical conflict so quickly come into schizophrenic constellation with one drug, be it heroin, morphine or alcohol. The same happens in reverse, when the patient is on drugs and then suffers a conflict.
2. The second possibility is that the patient is brain damaged or has had a brain operation. The brain no longer vibrates in the normal rhythm. This is the difference between a healed HH and an operated HH: in the first case, the [damaged] brain returns to its normal rhythm after repair, while in the second case, the operated or injured brain can never retrieve it.

   By definition, in the case of a brain injury or operation, it is enough for a patient to suffer an active conflict on the same side as the injury to go into an immediate schizophrenic constellation. This has important consequences for those patients who have had brain operations and suffer an active cortical HH that is, speaking figuratively, located close to or immediately on, the site of the operation. In the case of spontaneous healing with glial scarring, that would constitute a very normal relapse. However, in the case of a brain operation, there cannot be a normal relapse. Instead, the patient falls instantly into schizophrenic constellation. He will have enormous difficulties resolving this conflict.

14.4.4 Fronto- occipital constellation

Although the schizophrenic constellation signifies a transversal opposition of the HH affecting the right and left hemispheres (to a greater or lesser degree), the fronto-occipital constellation is where the patient perceives a danger from the front, as well as perceiving or suspecting a danger from behind. This is a bad situation for the patient, often with no way out, and can result in what used to be described as schizophrenia. Additionally there is the combination with right frontal and left occipital or reversed, which has the patient in schizophrenic constellation because both hemispheres are affected, but he is also in fronto-occipital constellation because he has suffered a frontal and an occipital HH.

If we imagine both hemispheres as not quite complete eggs that have been somewhat flattened in the middle when laid next to each other, every point on the one eggshell with any point on the other can, in a way, create a schizophrenic constellation. There are countless possible combinations corresponding to the many manifestations we know from psychiatry.

It is also important to determine the individual HH - there can be more than two; there can even be three or four - because only these HH's can give us information on the contents of the supposed or even real delusions which are quite irrational in reality, but once had very real things as a basis, things that will reveal the patient's conflicts.

A patient with two motor conflicts on each of the two hemispheres usually has a motor manifestation, i.e. a tick, or repetition of a certain movement or, in a situation related to the conflict, engages in a particular, apparently nonsensical motor activity which will be understood once we reflect on the two DHS's.

Another patient with concurrent foci in the right and left cortex, corresponding to two fear-from-behind conflicts, will have a persecution mania, which is not as 'mad' as we once thought. On the contrary, it represents an effort to get rid of the fear from behind, i.e. to solve the conflict by avoiding every single possibility - be it ever so trifling - dictated by his obsession, which we simply have not understand until now. If the patient is in opposition in the right and left temporal lobes, each with a territorial conflict, i.e., an active sexual conflict focus, then he is in the so-called post-mortal-schizophrenic constellation, i.e. he is thinking constantly about the time after his death. This was seen in the past as having no meaning. Today, however, we begin to understand that, biologically, the patient with two such conflicts goes into a waiting stance, or submersion, and is basically thinking mostly of the time after the biological rebirth, when he has resolved his two conflicts.

14.4.5 This brings us to the significance of the schizophrenic constellation of the cerebral cortex

If the patient suffers a conflict, he can solve it in the usual way by thinking about it continuously, creating maximal stress on the organism, not sleeping at night, losing weight and having cold hands and cold skin. In short, he is in stress tonus, or rather, in sympathicotonia. With two conflicts, he goes into double sympathicotonia. But he cannot solve two conflicts at the same time so the computer shows an 'error', it cannot co-operate any more.

This is not senseless from a biological point of view. On the contrary, the patient now waits for better circumstances, for 'good weather', for the possibility of an automatic resolution. If the individual only has a right territorial-conflict, periinsular on the right of the temporal brain, he must resolve it as quickly as possible otherwise he will die of a heart infarction if the resolution comes too late.

But importantly, if the affected person suffers a new conflict on the left side he goes into schizophrenic constellation and that implies that there is almost no conflict mass. Such an individual is literally waiting for better weather, i.e., he can wait until the conflict opponent dies a natural death and then he will rise like a phoenix from the ashes and may even take over the leadership of the territory. This means that the person in schizophrenic constellation cannot or will not find a solution for either one or the other of his conflicts because the most important one is not solvable for a specific reason. He therefore waits for the spontaneous resolution of the most important conflict through a change of circumstances, whereupon the second will go into resolution automatically.

In a way, Mother Nature has created a special kind of balance here of two active conflicts while pursuing a meaningful goal; she takes this individual temporarily out of the race and keeps him in reserve for a later emergency situation of the specific social group, the family or the pack.

14.4.6 The schizophrenic cerebellum constellation

Outside of the cerebral cortex schizophrenic constellation, we are aware of the cerebellar schizophrenic constellation that causes a passing withdrawal of the patient's emotions. An example:

A mother was deeply offended by her adult daughter's disrespectful behaviour as she took leave of her. The mother instantly suffered a carcinoma in the left mother-child breast, with an active HH in the right lateral cerebellum. A few seconds later, her husband of 40 years who was sitting next to her and with whom she had never exchanged an angry word, said: „You stupid old woman!" In that very second she suffered an adenoidal carcinoma of

the right breast with an active HH in the left lateral cerebellar hemisphere. The patient reported that her world had just collapsed and she felt as cold as ice, with no feeling. She suffered for many months, with resolutions of short duration and night-sweats (a sign of tuberculosis which sometimes led to the destruction of one or other nodule); after which there were relapses when she was in a kind of schizophrenic constellation. She would do crazy things, all manifestations of this total emotional numbness.

14.4.7 Sequence of DHS in the cerebral cortex

A right-handed man normally suffers his first conflict in the right hemisphere, and the second conflict cortically on the left. This order is reversed with a left-handed man. A right-handed woman suffers her first conflict in the left hemisphere cortically, and the second conflict in the right hemisphere cortically. A left-handed woman experiences it in reverse. There is an exception: the milk ducts for the right and left breast are equilaterally tied to the cerebellum and they are always unequivocally defined as child-breast or partner-breast. If a right-handed woman suffers a separation conflict from her child, the impact is always on the right cortical area in the sensory cortical centre, whether it is the first or the second conflict. This is because it is tied to the right lateral area of the cerebellum, which would react if it was a worry or quarrel conflict about or with the child, not a separation conflict.

A left-handed woman shows the reverse. It is the right breast that would be affected in a conflict of separation with her child and one would look for the corresponding focus for the ductal carcinoma in the left sensory cortical centre, and this would be tied to the relay in the left lateral cerebellum, which would react if the conflict were mother-child worry or mother-child quarrel of a left-handed mother.

The milk ducts which correspond to the left breast in a right-handed mother and clearly define the mother-child breast, may be joined in definition with the flexor muscles of the left arm as being for the child, as well as the inside of the skin of the same arm, the hand and the left abdominal portion of the skin (because humans, too, had a mammary ridge which is now only rudimentary) and the inside of the left leg which is where the child of a right-handed woman normally sits.

It is exactly the opposite for a partner. One has to separate from this the outside of the arm and the leg that means separation as well as defence. For a right-handed woman, the left arm is the 'shielding' arm while the right one is the 'hitting' arm.

14.4.8 Sensitivity of the periosteum

These rules are also valid for the sensitivity of the periosteum where the conflict content is always a separation, with the addition of pain, inflicted or suffered, and is a brutal separation. Analogically, the same topographic correlations are valid here as well.

There is therefore only one schizophrenic constellation with periosteum conflicts (sensory paralysis of the periosteum) on both hemispheres. The neurologist cannot detect anything other than perhaps a somewhat lower temperature of the affected extremities than in the non-affected ones. This explains why there is an organ correspondence for each and every conflict and why at the same time schizophrenic patients do not show organic disease, since apparently they have no lack on the organic plane. This was because we could not examine them properly and did not know how to understand and correlate the HH in the brain.

14.4.9 Sequence of the HH in cerebellar conflicts

The rules of impact or the activation of an HH in the cerebellum are not the same as those in the cerebrum; they refer strictly to mother-child, partner-and local organ-reference.

If a patient is stabbed in the abdomen, he develops a peritoneal mesothelioma and may even develop a melanoma externally at the corresponding peritoneal area.

If a right-handed woman has a mother-child-worry conflict, she reacts with a right lateral cerebellar HH and a carcinoma of the milk-glands in the left breast. Strangely, if she has several children, she can react twice on the same breast with a carcinoma, one after another, in such a way that they can both be active simultaneously. Other than the noted exception, in the case of the cerebrum, this is avoided if a right handed female who suffers a sexual conflict goes into amenorrhoea from that instant, reacting in a more masculine way; her next conflict impacts on her as a 'man', on the right side, specifically on the right territorial relay. It happens this way with all cortical conflicts with the noted exception. The rule for the cerebellum is the local organ correspondence.

Example: a radiologist showed a female patient a tumor on the right of the x-ray saying, „We must operate this". In that instant the woman suffered an attack against the thorax conflict and a thoracic pleural effusion of the right side in the healing phase, which no one could understand because the tumor was on the left. However, if we visualize the scene with the radiologist across from the patient while looking at the x-ray, his indication affected the woman on the side she perceived, which was the right side.

14.4.10 A schizophrenic brainstem constellation

I have been unable to observe this borderline case unequivocally; this is, however, not valid for the cerebellopontine angle where the so-called acoustic neurinomas have their relays for the middle ear mucosa and the mastoid process; they react half as an adeno-carcinoma, the other half already as an adeno-mesothelioma. This means it does not make a cauliflower type of cancer, but a more flat type of surface enlargement in the columnar epithelium mucosa in order to be better able to receive the sound or the information. The embryologists and histopathologists still assign acoustic neurinomas to the brainstem because of the columnar epithelium of their old intestinal mucosa. I still cannot be certain if these paired nuclei of the acoustic nerve - which, in any event, do not cross - could cause a kind of schizophrenic constellation, but neither can I exclude it, because I have not observed enough cases.

14.4.11 Developmental retardation

In psychology, psychiatry, pedagogy etc., we make constant observations regarding a phenomenon we have not explained until now: developmental retardation. It has been interpreted partly as an organic-brain process, e.g. as early childhood brain damage, in addition to being observable among mental illnesses and mood disorders. We did not think that the latter had a brain organic cause, but was only a purely psychological disturbance.

The NEW MEDICINE gives us - based on facts - an illuminating explanation: the individual becomes 'conserved', 'frozen', in the expectation of better times. Observed more closely, from the point of view of the conflictive situation, the situation looks relatively simple:

The individual, still in the developmental stage, cannot, for instance, resolve a decisive biological conflict in the time frame provided by nature because it would seriously compromise further development. For some reason that needs to be explored in each individual case, Mother Nature allows a second biological conflict to be suffered that

guarantees survival through the schizophrenic constellation. Should the individual continue his development into maturity in spite of the schizophrenic constellation, there would be immense negative consequences.

If a little girl suffers a separation conflict from her father because the mother gets custody when her parents divorce, should the conflict remain active for too long, at some point she would develop a serious neurodermatitis with memory loss from which she could die. If, for instance, a motor conflict is added (of not-being-able-to-hold-the father), the child's development will come to an immediate standstill. This guarantees the following two actions:

1. There is almost no conflict mass built up.
2. The little girl can resolve the conflict when she gets older.

For the girl in this case, 'better weather' means being older. The moment she turns 14 she can decide by herself which parent she wants to be with and both conflicts will be resolved simultaneously. In a very intelligent manner, maturation stays at an infantile stage so that the individual does not represent competition, which, in this connection, is an important moment of survival. Had she continued to mature, independent of the unresolved conflicts, she would never have had the chance to resolve these conflicts again, because her development and consciousness would be at an entirely different level. She can resolve her conflicts and catch up with her maturation when the outer circumstances change, which is an incredibly interesting aspect.

There are many special education programs for developmentally retarded children, and even for college students and university graduates whose maturity index corresponds to puberty or pre-puberty stage. The number of people affected is greater than generally accepted. It is only necessary to be at the level of maturity of a thirteen year old to achieve an academic degree. General human and sexual maturity is not essential to attaining purely intellectually defined college degrees. The intelligence and aptitude tests used tell us nothing of a person's maturity level.

14.5 Avoiding the so-called 'vicious cycle' (devil's circle)

In my book '*Legacy of a NEW MEDICINE*', I describe the vicious cycle as a dangerous mechanism that manifests as relapses and new successive conflicts combined with a psychic self-build-up, all of which are caused by doctors inducing panic and panic in general so that the patient falls back into conflict again and again. This should not happen; it does not happen with animals because diagnoses and prognoses cannot cause them panic.

For us, however, there are vicious cycles that we find difficult to break because they seem to run their course automatically.

Example:
A patient allowed her breast to be amputated because it had a nodule that had stopped growing as her conflict was resolved, but the node bothered her. I advised her to have the gynaecologist merely excise the node but not the entire breast. However, the gynaecologist argued with her and convinced her to have the whole breast amputated. When she came out of the anaesthesia she did not suffer a conflict because she had agreed to the amputation. Six weeks later she put on her German traditional folk costume. As she smoothed it down in front of the mirror she was startled because the left breast was missing. The costume's front was not filled, and it did not sit properly. At that moment she suffered a disfigurement conflict at the site of the amputated left breast. In the meantime, a melanoma started growing. This began the vicious cycle (devil's circle): every time she saw the melanoma, she felt that she was deformed and soiled. The melanoma continued to grow. The vicious cycle continued: since the patient felt she was deformed on the left side of the

thorax, which might have happened as a DHS when she originally saw her mirror image), she suffered a self-devaluation conflict for the local area on the left side of the chest. The organic correlates of this conflict are the ribs, the left half of the sternum. A surgeon was found who had the courage to make an excision of the melanoma with a skin graft without injuring the periosteum, in spite of the osteolysis of the sternum and ribs. The operation was successful but the patient developed an enormous swelling of the periosteum of the ribs in the area that had the osteolysis, and the left half of the sternum. Fortunately, she knew the NEW MEDICINE and understood that this was merely the healing of the skeleton, which would take 8-12 weeks, and that it would be painful but not dangerous. Fortunately, the patient endured everything and healed. Had the understanding surgeon not been found, the patient would have died as a result of this vicious cycle.

There are similar vicious cycles in nature that even make sense. For example, many patients who suffer a paralysis also suffer a self-devaluation conflict relating to the portion of the skeleton in the limb that they can no longer move. It is hard for them to come out of the first conflict: for instance if there is an osteolysis of the femural neck with subsequent fracture, then not only can they no longer walk because of the motor paralysis, but they cannot even walk in place, because of the fracture of the neck of the femur. No matter how cruel it sounds, in nature, this patient would have been 'fodder for the lions'. Fortunately for man, however, it is possible to break out of such a vicious cycle by providing a prosthesis for the hip. This does not solve the first conflict of the paralysis, but at least the vicious cycle has been disrupted.

There are also vicious cycles that originate through lack of understanding or genuine interference with the healing process. Primary polyarthritis is a chronic condition that rests on the following mechanism: the patient suffers a clumsiness conflict relating to his fingers, affecting the skeletal structure of the hand. If he resolves this conflict, there is a swelling of the periosteum of the hand, since there is often osteolysis close to the joints. The edema swells where there is the least resistance, that is, into the joints of the fingers or the joints of the hand. This swelling makes the patient feel even clumsier than before, so that in the middle of his resolved conflict (otherwise there would not have been a swelling of the joints) he suffers a relapse.

The relapse causes the swelling to recede, not because it is healing, but because it is in a new conflict active phase that is creating osteolysis instead of re-calcification. In other words, the process is reversed. If the swelling recedes and the patient feels more dexterous, he can resolve his conflict. The resolution, however, again leads to the swelling of the joints. Thus the process continues in waves and can stretch out over many years until finally the hands become deformed, which then cement the remaining moments of clumsiness.

There are similar phenomena for all osteosarcomas, especially frequent in the knee, the so-called poly or mono-arthritis or the so-called joint rheumatism e.g. of the knee. The so-called acute joint rheumatism is the healing phase, strictly considered a joint proximal bone sarcoma preceded by a bone osteolysis in the proximity of the bone. Due to significant swelling and the joint deformation that is really only temporary, it is possible to suffer a sport-inability conflict relapse, since the patient is unable to run at this time. I have already mentioned that in the past no patient had ever died of acute joint rheumatism. Today, however, these cases are all diagnosed as joint osteosarcomas and the mortality is high. Aside from this, if the patient does not die, he falls into a vicious cycle that leads to an increasing deformity of the knee.

In the NEW MEDICINE we must be very protective. Every word should be put on a golden scale, because each ill-considered expression can precipitate a new conflict and lead the patient into a vicious cycle.

The words 'danger of ileus' can precipitate a starvation conflict the moment the words are spoken, as can also happen with an intestinal carcinoma, because the patient imagines that food will not be able to go through the intestine and he will therefore starve. He consequently suffers a solitary adeno-carcinoma of the liver in the right dorsal liver area. From here on, the vicious cycle is closed, because anything that happens with the intestines in the future will create relapses on this liver carcinoma. The same occurs when one is informed that surgery may be necessary due to any intestinal or abdominal condition - even a cesarean section. For most patients, this will result in a peritoneal mesothelioma, that is, a cancer of the abdominal sac. This is resolved, however, if the operation is done quickly and successfully, but can relapse any time there is a similar danger, e.g. fear of an operation, renewed cesarean, and the relapse can lead to a renewed peritoneal mesothelioma.

Ascites, the healing crisis of mesothelioma, can itself become a vicious cycle by connecting with the original conflict, which means another operation. Therefore, the surgeon 'planned' another attack.

Every time the patient goes into the healing phase, there is ascites. He then panics, the panic causes a regression of the ascites, the resolution of the panic causes the ascites to come back as a sign of healing and this process continues on each time with a greater danger of escalation.

Punction of such an ascites is also a vicious cycle. When the doctor advises that he must puncture the ascites in order to drain it, the patient experiences the punction as a renewed attack against the abdomen, which it is in the truest sense of the word. He suffers a relapse that is not visible, since there has been an extraction of some litres from the ascites. If that were not the case, one would notice the ascites receding and the abdomen becoming smaller, not because of healing, but because of the conflict relapse. If the patient calms himself, the relapse resolves and, as a consequence, the ascites increases significantly.

This terrible sequence can continue for months until the patient dies in this vicious cycle, specifically because the level of protein in the serum drops significantly. The serum in the blood must substitute the serum in the ascites; the patient starves, thanks to the ascites punctions. All of these very logical processes and dangers require that physicians have a healthy human understanding, tact and capability for empathy as well as a high degree of clinical knowledge. It is exactly these kinds of vicious cycles that show us that these complex situations should not be referred to a psychotherapist who would engage in therapy without the required medical knowledge.

15 The Biological Language of Man and Animal

We have tried to understand the language of animals since time immemorial. We expect our dogs, horses and cows to learn our language and to understand our commands so that we can train them. We know from their ancient religions that the Hittites, the Hindus, the Greeks and the Germanic people had a very intimate relation with their animals; they regarded horses as their friends. The gods transformed themselves into animals and many were conceived in animal shape. Animals had a soul and a language, and the gods conversed with them. Now and then some humans were also granted this special ability. The cosmos was not in any way divided. There were communication difficulties, but they were not insurmountable. The more archaic and less sophisticated the religion, the more likely there was dialogue between animals and the humans who reared them.

With the birth of the Islamic and Christian religions, this situation completely changed. Disdain for animals ended all conversation with them and degraded them (and plants) into purely commercial articles, to be used and sold. Human beings became brutal and impoverished. Even St. Francis of Assisi, a small ray of light, was unable to change anything. Instead, the animals were denied their soul and their language. „Animals cannot feel pain because they have no soul, or at most, they have a group soul; they cry from instinct; it's a reflex. We'll see to it that they won't cry any more!" say the animal haters, but our friends the animals cry silently, even during torture.

'Behavioural research' has recently taken on a special meaning. We are learning to understand things that were once incomprehensible. We are now forced to communicate with our fellow-creatures, the animals, but the research will remain incomplete as long as we speak only of instinct and behaviour and do not grant them a soul.

Only then will we truly be able to communicate with them. The problem with our attempt to communicate has always been our inability to understand animal language. Perhaps one day we will decode the sound frequencies that dolphins emit, and maybe in time we will make sense of the sounds of all animals. Every dog lover knows that a dog speaks with his whole body and is understood by his own kind. He speaks with his tail which he puts up or down and which he wags; he speaks with his fur, which stands on end; with his gestures, his eyes, the baring of his teeth or flattening of his ears; ritual actions speak of his subjugation to a victorious opponent when he offers him the jugular. It is not a language we can hear naturally, but it is how a dog speaks to us. It is how all animals communicate with each other, depending on their kind. This makes them different from us, not more stupid.

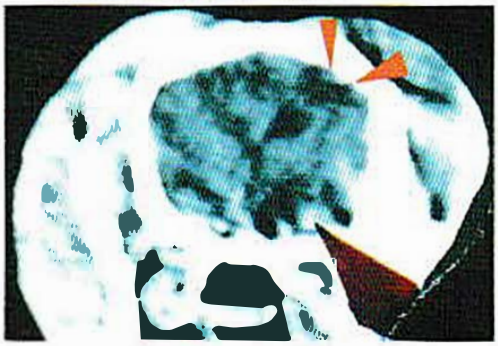
But there is a language that we DO share with the animals and that is the 'inter-animal biological language' of our brain. Even though I consider myself to be Francis of Assisi's modest descendant, it is very clear, in principle, that this common language is understandable. It may look a little complicated at the moment but through the CT, we are able to have a 'conversation' with any horse or mouse, because the brain's language, specifically the inter-animal language, is analogous to human language, especially where it concerns the locality of fears and conflicts in the brain. A mother-child conflict, a self-devaluation conflict, a fear-from-behind conflict, are all in a comparable area in humans and mammals and all create HH's in equivalent areas of the brain and conform to the course of conflict similar to the human brain.

The dachshund shown below, who always begs for a sausage with her left paw, is obviously 'left-pawed'. She suffered a teat-Ca and so-called 'stomach-epilepsy'. Her old

mistress had died and her daughter had taken the dachshund home to her apartment and tobacconist's shop. The dachshund suffered two conflicts simultaneously:

1. A nest-territorial conflict with accompanying right teat-Ca (instead of left, because of left-pawed-ness).
2. An identity-conflict with accompanying stomach ulcer (instead of rectum ulcer-Ca, because of her left-pawed-ness).

Had the dog been right-pawed, her HH would have hit the right cerebellum (with left teat-Ca) and the left side of the cerebrum (with-rectum-squamous-epithelium-ulcer-Ca). Because she is left-pawed, we find the HH on the left cerebellum and the accompanying carcinoma in the right teat, as well as the other HH in the right hemisphere in the stomach relay - just as one would with a 'right-pawed' female dachshund with an identity conflict. I was told that the dog always had her epileptic vomiting attacks when the new owner's brother came for a visit. The dog, which had a 'biological identity conflict' (I don't know where I live), hoped each time that he would take her back to her former home where the brother still lived. Whenever she came to terms with not being taken back, she would have her epileptoid crisis.



And this is how (see arrow), with our brain, we accurately 'understand' the language of the little dog that had two operations performed on her teats and was close to being put down.

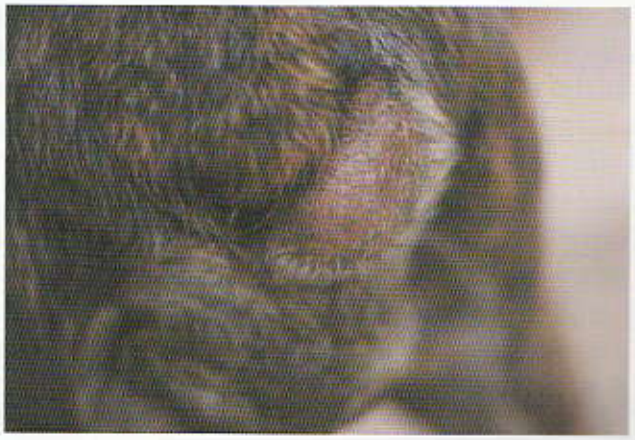
Once we understood the little animal's language, the therapy was relatively simple: we had to provide a permanent conflict resolution for the biological identity conflict 'I don't know where I belong'.

We solved the problem by asking the owner's brother not to visit for a few months; and every morning, I took her a sausage that she loved. Soon enough, the little dog knew where she belonged. The teat-ulcer stopped and needed no more surgical attention. The stomach epilepsy, which had occurred twice a week after the visits of the owner's brother, also abruptly stopped. No one talked about 'putting her to sleep' any more. She has been very happy these last four years. All we needed was to understand our 'comrade dachshund's' language; the therapy fell into place quite simply, it was logical, consistent and necessary.

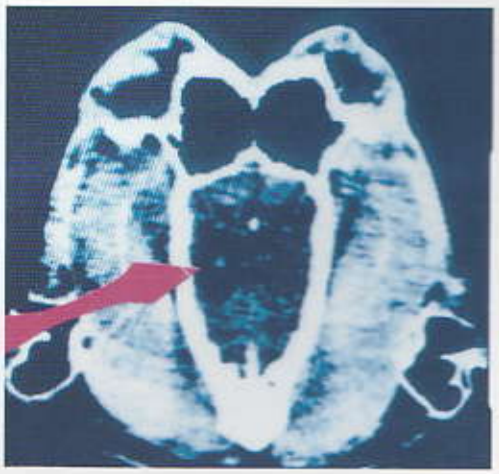
Our boxers, Basso the male on the right, and Kimba the female on the left, were 'transplanted' from Cologne to Rome.

Kimba suffered an identity conflict ('where do I belong?'). She had haemorrhoids after a rectum-ulcer-Ca in the PCL-phase.

Large haemorrhoids, above.



CT of the dog's skull. A large edema in the rectum relay of the left temporal lobe as a sign of the PCL-phase ('I now know where I belong'). By that time, the boxers were inseparable.



15.1 The biological conflict in the embryonic phase

Man (like animal) is an independent being from the time of conception. As such, he lives through the entire phylogeny during his intra-uterine ontogenesis. He can suffer biological conflicts during all the phylogenesis - the oldest being the archaic conflicts of the old brain directed organs. Why, during the recapitulation of the phylogenesis in the womb's ontogenesis, should he not suffer biological conflicts in that very place? He can and does suffer them, and as an independent being!

One of the ways is to suffer a biological conflict that bypasses the mother. Another way to suffer a biological conflict is for the mother to panic, causing the supply vessels to the placenta to close and the child to die of hunger. The mother, of course, can also suffer a conflict, but she will remain on hold until after the pregnancy which takes absolute precedence. This changes the moment the child in the womb gets into the CA-phase and aborts itself, commits suicide, as it were. Labour starts, and the pregnancy is biologically over from then on. The mother can now, in a counter-move, terminate the (no-longer existent) pregnancy.

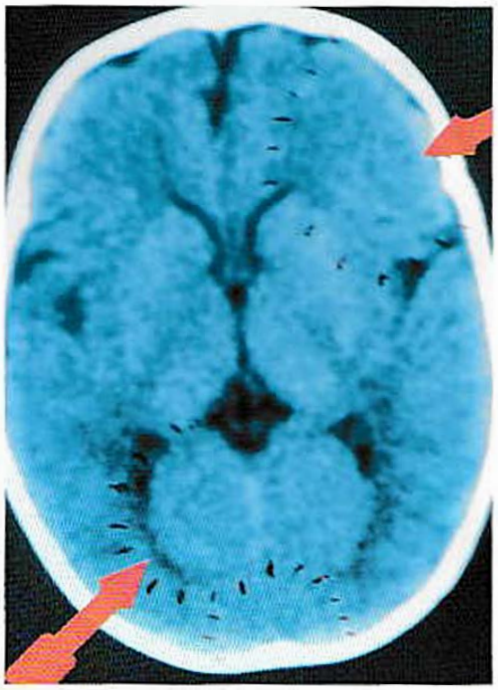
Some examples:

15.1.1 Intra-uterine liquid conflict with territorial fear and fear from behind conflict

A young midwife, five months pregnant, was rinsing instruments at the delivery room sink. She was close to a foreign woman in labour who was panicking because of her poor understanding of German. She suddenly screeched hysterically as if she was being impaled, and everyone in the delivery room began to tremble. At that moment, the embryo in the young midwife's womb suffered both a water conflict and a territorial fear conflict at the same time. The embryo would associate water with very great danger because of the blood-curdling screams of the woman in labour and his mother's cleaning of instruments under running water and audibly splashing. The midwife went into labour that evening with light bleeding which threatened an abortion. She stayed home for a few days until the situation calmed down; or so she thought.

Upon returning to the delivery room, and again while rinsing instruments, she heard women howling in labour, just as her unborn baby had done, not as horribly frightening, but bad enough. Labour and bleeding occurred several times, again threatening abortion. In the middle of her sixth month she decided to take early maternity leave. The foetus realized this and had no more relapses, so the biological conflict was resolved. After birth, the child had a left-kidney cyst and a cough that lasted for a while and the mother noticed that its vision was poor. Unfortunately, she was persuaded to have the child's kidney excised and, despite its well being, to be treated with chemotherapy.

Relays right frontal: Bronchial-Ca in the PCL-phase, organic-clinical: severe cough.
Left kidney relay bottom left: in PCL-phase, organic level: left kidney cyst.



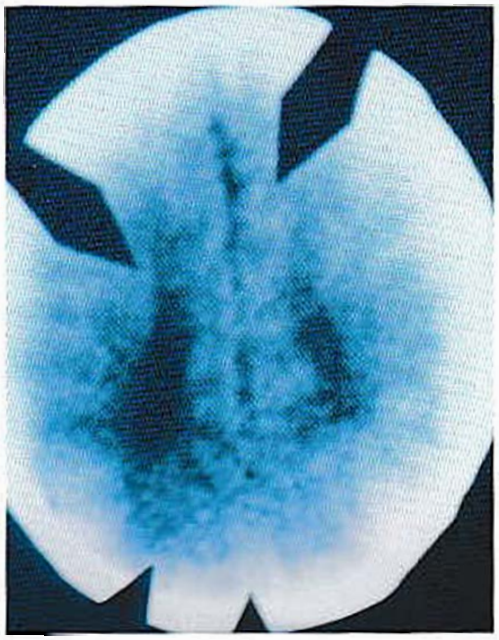
15.1.2 The most common intrauterine conflict: The circular saw syndrome

By far the most common embryonic conflict is the circular saw syndrome. We already have thirty cases of it. Its mechanism is as follows:

Humans have the same inherent codes as animals. Men, lions and other beasts of prey have shared the same environment for millions of years. The lion's roar is an alarm signal for us; it is innate, and even the embryo recognizes it and becomes extremely distressed.

A circular saw sounds like the roar and hiss of a beast of prey. In our civilization, the pregnant mother-to-be has largely lost her instincts. Without a second thought, she might stand beside a working circular saw with no idea that the child in her womb will get into a terrible panic; it thinks that a lion is going to swallow the mother - along with the embryo. Depending on the first appearance of the biological conflict, its extent and frequency and, of course, how the embryo experienced the DHS's biological conflict, there will be motoric or sensory paralysis or both combined, and often a schizophrenic constellation as well after the birth. This can happen if the child is exposed to a similarly frightening noise like the sound of a drill, when it will be hit with a new conflict on the other cortical side of the cerebrum. There is a danger that the child will remain with these two biological conflicts in schizophrenic constellation if the unsuspecting parents push the baby carriage past another circular saw, for instance. In the countryside, these are almost household appliances. Our brain is simply not programmed for the noise of civilization and associates it with dangers that are engraved into it because of our phylogenetic adaptation.

15.1.2.1 Case of a new-born with equinovarus and diabetes

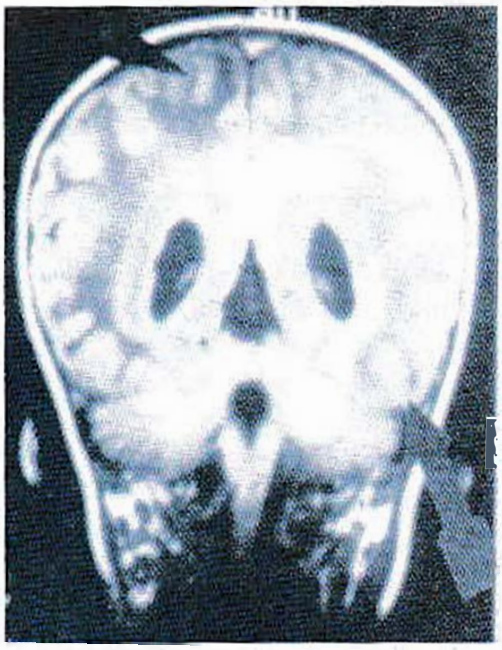


The CT is of a baby a few days after birth, born with a clubfoot (hanging healing = spasticity of the left leg).

There was also a second motoric conflict for the right leg and arm and diabetes. The child resisted and wanted to flee because the parents shouted at each other constantly during the last part of the pregnancy. The ensuing panic put the child into schizophrenic constellation. It suffered two conflicts in the womb:

1. Diabetes, resistance conflict
2. Motoric conflict of the right calf with equinovarus after birth, i.e., spasticity as a sign of hanging healing. The relapses continued because the parents persisted in fighting after the birth.

15.1.2.2 The 'language of the brain' in infants. Death of a baby because of hospitalization damage



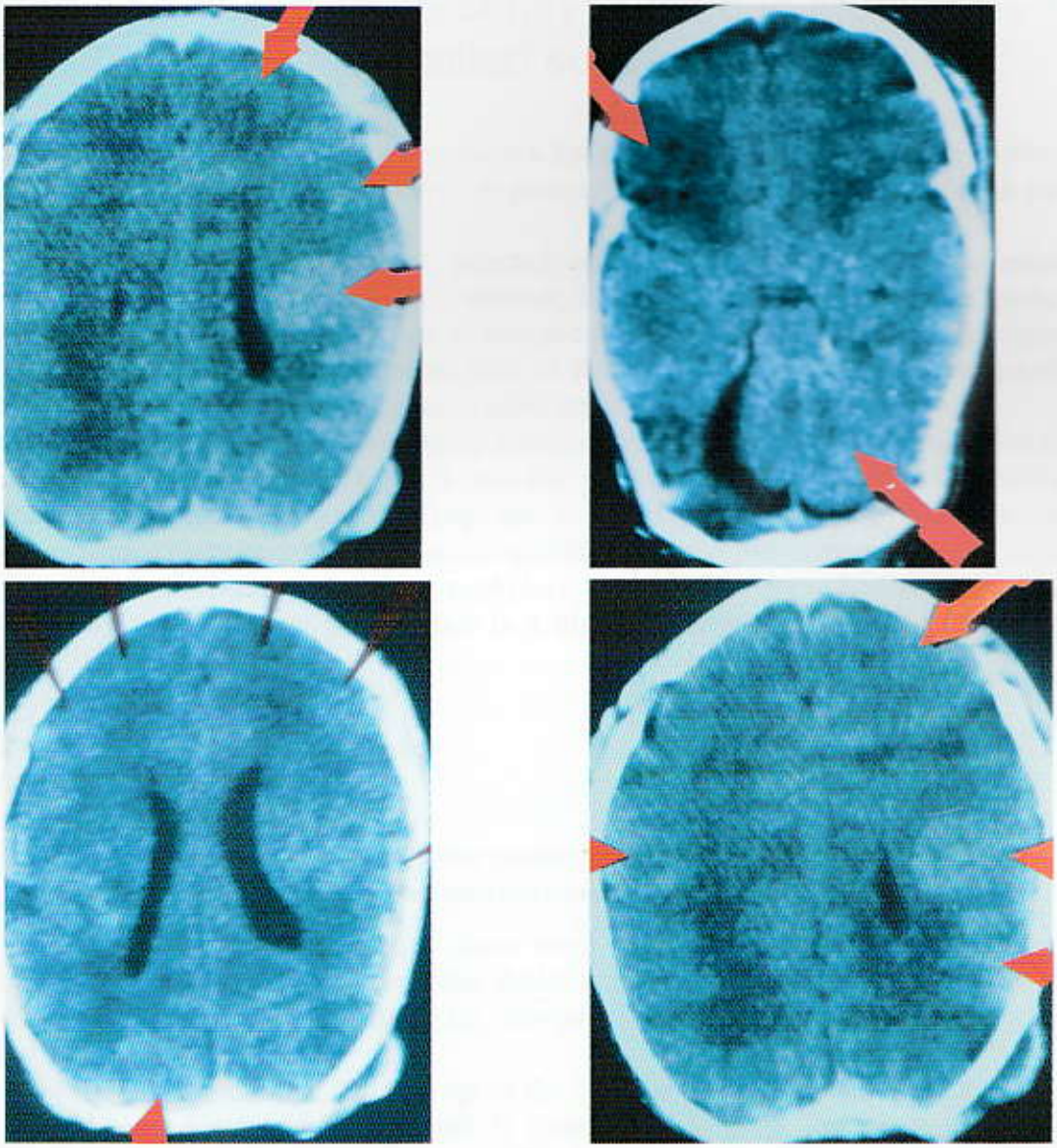
Stomach ulcer because of hospitalization and a shunt operation with all the additional damages suffered unnecessarily by the 1½ year old child, causing cachexia and leading to his death.

1. Partial motoric paralysis, right arm, in resolution,
2. Territorial anger conflict (stomach ulcer) in resolution, continuous vomiting of blood (hematemisis) in the PCL-phase.

Partial motoric paralysis (right arm) resulting from the vaccination against diphtheria and tetanus administered at age 3½ months (upper arrow, cortical motoric centre). During the vaccination, the little boy was tightly wrapped in a cloth towel and 'bound'. He suffered a conflict of not-being-able-to-defend himself as well as a territorial anger conflict with stomach ulcer (right arrow).

Because of the ensuing epileptic crisis, he was hospitalized in the clinic and suffered another DHS, renewed epileptic crises with territorial anger (and stomach epilepsy in the healing phase) and continuous relapses, an aggravation resulting from the hospitalization, which finally resulted in his death.

The inter-animal (biological) language is unequivocal and explicit: let me be free and leave me to my mother! This case was particularly contemptuous because the so-called judge declared that the mother, who had healthy common sense, was a minor and, over her and my objections, ordered surgery to be performed on the child, whereupon it died.



Case K.R., d.o.b. May 10, 1990, CT of May 16,1990

It is very easy for an expert to understand the clear 'language of the brain' in the case of a six-day-old male infant from Holland. He had been stuck in the birth canal for ten hours. There was severe hypoxia (oxygen deficiency) during the birth. The child suffered a frontal fear conflict with a territorial conflict and a territorial anger conflict (all on the right), a fear from behind conflict, a further focus in the peri-insular area on the left side, a thalamus conflict (extremely serious personality conflict with severe chemical imbalance) and a serious loss conflict in the right testicular relay (for the left testicle). All of these foci were regarded as brain tumors. The infant had been in schizophrenic constellation during the birth. Six days later, everything was healing and had become edematized.

We can only understand the fear and the language of an infant when we reconstruct the birth as accurately as possible and then imagine the conflict sequence and its impact. Many CT's of new-borns immediately after a difficult birth look like this. Fortunately, the brain is young and the roof of the skull elastic. But the 'language of the brain' is very urgent: recovery from the fears of the birth.

16 Statistics as presently applied in Medicine - The so-called successful cases

The intention of statistics is to introduce a list of facts, as in a graph. Then another list of facts is presented. Thirdly, the curve or parameter A is associated with curve or parameter B in a causal manner.

The content of the curves is selected and arbitrary. Calculations and conclusions reached follow in a formally correct manner. So-called knowledge in official medicine has always been established by the use of statistics. As long as it is possible to aggregate facts, statistics are valid. When different lists of facts have to be connected statistically in a causal sense, however, things become more misleading.

For example: there are increasingly fewer storks, so it follows statistically that there are increasingly fewer babies, since it was the storks that brought them. Shepherds in the Caucasus do not get cancer. They eat a lot of sheep's cheese with the statistical consequence that sheep's cheese is anti-carcinogenic and prevents cancer (*Scientific paper from the professorship for cancer prophylaxis at the University of Heidelberg/Mannheim*).

In my view, the use of statistics is a highly controversial practice of the so-called scientific method.

An example:

a) more cars are being produced
b) more streets are being built

Possible statistical correlations:

1. because there are more cars, more streets have to be built
2. as more streets are built, more cars are manufactured

Since there is limited information about most phenomena (without regard to the hidden background difficulties), it seems that statistics are typically employed where sampling or data collection is relatively easy; e.g. mortality statistics in connection with geography, nutrition, pollution, etc.

The mistake lies in the fact that out of the hundred possible causes, only the one that fits is used, and a statistical likelihood is constructed without investigating all the other possibilities. The fact that there is very little possibility of a serious conflict for a shepherd in the Caucasus is not even considered as a potential cause.

Similarly questionable results can be found if a comparison is made of a group of poor people from a socially weaker level - which is almost a given in surveys of strongly polluted areas due to industrial emissions or other toxic materials - with a group who live in unaffected areas. For people who live in Bitterfeld or Leuna, environmental pollution is a very important issue. Yet, the following type of questions is not considered:

- the social classification of the population under investigation
- whether they come from areas with significant or threatened unemployment because of site restructuring or mass-layoffs, such as in the heavy industry sector
- to what extent the awareness in an area with significant environmental pollution combined with sensationalist press coverage is a factor in generating conflict. (Example: the 'horror stories' in the press of some babies born without hands which was supposedly caused by water pollution in the North and West Atlantic where the mothers of the affected babies live.)
- would the hopelessness, poverty and fear of serious disease suffered by the people of Bitterfeld and Leuna not be more significant statistical factors in the origin of disease?

- what is the interaction between life in a lower social class (with all the pressures that entails) and the awareness of having to work in conditions that expose one to carcinogens and the conflicts this can generate?

There are no statistics as yet from the point of view of the NEW MEDICINE. There would be other explanations that could be proven with the greatest accuracy.

It is generally thought that aniline medication leads to papilomas of the bladder or renal pelvis or mucosa of the rectum. Here, the NEW MEDICINE can provide a very simple explanation: The affected individuals can experience a biological conflict of 'not being able to mark the territory' because of the change in colour and odour in the urine and faeces. If there is a DHS, this conflict, which exists in males and females, can lead to renal pelvis or bladder ulceration in right-handed males, and in right-handed women and left-handed men these organic symptoms would correspond to an identity conflict and a territorial anger conflict. By then, the papilomas are in the keratinized and healed state, but up to now, they have been erroneously diagnosed as carcinomas; in reality they are only harmless papillae.

If a survey were to be conducted of the populations that live close to atomic reactors, it would no doubt emerge that they were more than likely to be poor people; rich people do not need to live near an atomic reactor. One would therefore come to the conclusion that the poor get more cancer than the rich. However, there is no mention in the statistics that one group is poor and the other is rich; only that some live close to the reactor and the others do not. I do not know a single wealthy person who would not immediately sell their house and move away the moment there were plans for building a reactor close to where they lived. Many statistics rest on the basic observation that the poor have more diseases than the rich.

Every textbook in oncology states that circumcision lowers the incidence of cervical carcinoma, therefore it is anti-carcinogenic. This assessment, along with its ridiculous conclusions, came about in the following way: Some Israeli doctors studied a group of Israeli housewives to ascertain how often they suffered cervical carcinomas. They then used some Arab prostitutes as a comparison group, women who had indiscriminate sexual intercourse with circumcised and uncircumcised men. Obviously, by earning their living in this manner with everything that this kind of life entails, they suffered cervical cancer with far greater frequency than the Israeli housewives.

The conclusion was that since the Israeli housewives only slept with their circumcised husbands and the prostitutes slept with uncircumcised men, the cause for the cervical cancer had to be the male smegma - perfectly pseudo-scientific proof that smegma is carcinogenic. Knowledge of the NEW MEDICINE obliges the following comment: as we all know, the problem is that if two similar events affect two groups, statistics establish only one of fifty possible causes and drops the other forty-nine under the table. Such medical pseudo-statistics are certainly not science.

Statistics have always been a numerical aggregation of facts. The assumed causes have been statistically built after the fact. Furthermore, they have only been used in reference to the organic level and even there, given the lack of understanding of the interconnections, the knowledge of the two phased nature of disease was ignored. In the same way, the psychological and cerebral planes and the importance of laterality remained unrecognized. As for the epileptic crisis, the most frequent cause of death, not a word.

In hindsight one can say, with full authority, that most medical statistics have little value and make little sense.

Liver cell carcinoma is by far the most frequent kind of cancer in many parts of Africa and Asia.

Mozambique	70%	0f all cancers
Senegal	67%	0f all cancers
Bantu in South Africa	50%	0f all cancers
India, China, Taiwan and the Philippines	20%	0f all cancers
USA, Canada and Western Europe	2-3%	0f all cancers

(Neumayr, A and Weiss, W: Liver tumors-new aspects. Hepatogastroenterology 28:1, 1981)

As we know from the NEW MEDICINE, on the psychological plane, a liver cell carcinoma corresponds to the biological fear of starvation conflict. No wonder then that in areas of political conflict and famine, liver cancer is up to 35% as frequent as in areas where survival is assured and orderly as, for instance, in the USA, Canada and Western Europe.

Statistical surveys show the risks of cervical cancer nowadays to be: lower socio-economic classes, race (black women affected twice as often as white), early marriage, too young at the time of first sexual contact, and number of partners. This leads to the conclusion that male sperm is carcinogenic.
(Swan, S. H., and Brown, W. L.: Vasectomy and Cancer of the Cervix, New England Journal of Medicine, 301:46, 1979)

Knowing from the NEW MEDICINE that cervical cancer (in right-handed women) correlates on the psychological plane with a sexual conflict, this statistic only clarifies the fact that early and frequent sexual intercourse increases the potential for sexual conflict.

16.1 The statistic of rate of success in official medicine

Independently from what they report, statistics never compare evidence with cases where there has been no therapy (no operation, radiation, chemotherapy, etc.) To my knowledge, Abel (Heidelberg) is the first to dare mention this deficiency: '*Zytostatic Chemotherapy of Advanced Epithelial Tumors*'.

Faced with statements about discoveries of new methods against 'cancer', I always ask: „Please tell me whether it helps in the conflict-active phase or in the vagotonic healing phase?" Since the two phases are quite contrary, the new method cannot help both.

It is obvious that one and the same medication cannot 'help' in a phase that is fundamentally different from the other in all its possible bodily parameters and also help in the other. (I dare not ask the question: „To what extent does it make sense to therapeutically assist a meaningful healing mechanism in nature?").

The ontogenetic system of tumors logically shows that cytostatic agents only strengthen old-brain directed tumors because they increase stress levels. In the PCL-phase, on the other hand, cytostatic agents retard healing, they block it and hinder the work of the necessary microbes.

In any event, apparent symptomatic success in the PCL-phase of the cerebrally directed cancers is possible by immediately blocking any healing process with cytostatic means. This is the case in mesodermal diseases such as bone cancer (in the PCL-phase leukaemia and bone sarcoma), or in testicular and ovarian necroses (interstitial) (in the PCL-phase testicular swelling and ovarian cysts, later indurated) or in lymph nodes necrosis (in the PCL-phase lymphoma). The swelling of any furuncle, abscess or even bee sting can be reduced with cytostatic drugs. Cytostatic agents therefore only block the healing phases of mesodermal diseases and achieve a dubious symptomatic illusion of success.

A dissertation by Cl. Rohwedder, Dipl.-Psychologist and M.D. (1978) at the Medical University Clinic in Hamburg is very interesting in reference to this situation: 445 patients with squamous epithelium cancer of the bronchi and adeno carcinoma of the alveoli were statistically studied (*'Statistische Untersuchung ueber Bronchial Karzinom'*). This very learned work shows how difficult it is to compare these cases statistically.

Let us begin with operability: only 10% of the cases were operable. The surgeon obviously selected the best cases that he felt were operable which is why his results are marginally better than those of so-called radiation and chemo-therapists. Most deaths occurred after the first month. On average, all the patients died within three to four months. After 119 weeks, a little over two years, the last patient died, and it was discovered he had a pulmonary atelectasis, although he had had no complaints. 11% of the accidentally discovered lung cancers (in total 83) had an adeno carcinoma. These would previously have been undiagnosed (as lung cancer) but instead would have been diagnosed as tuberculosis. Also interesting to note is that 30% of the diagnosed patients refused treatment. Whether or not any of those survived longer was not reported. That would have been the most interesting question given the shattering therapy 'successes' of the standard medicine, since the last patient died after 119 weeks.

Let us look at these numbers from the point of view of the NEW MEDICINE:

16.1.1 Squamous epithelium Ca of the bronchi and pharyngeal arch duct cysts in the mediastinum

Diagnosis results exclusively in the PCL-phase (in patients with complaints) or after the healing phase (in patients without complaints). The conflict must have already been resolved. If the patients with the negative diagnoses could have come to us first, 95% of them would have survived as they were already in the healing phase.

16.1.2 Pulmonary (lung) nodules alveolar-adeno-carcinoma

Other than a few exceptions still in the CA-phase, most of these patients were either in the healing phase or already past it. Most had a smaller or larger pulmonary (lung) nodule as a residual condition that expressed their death fright conflict for a family member (also a dog) who had been in a serious accident. Such pulmonary (lung) nodules may be discovered years later during a routine investigation. These patients were no longer sick. They just happen to have lacked the tuberculosis needed during the healing phase, in which case they had a cavity and no one mentioned a tumor. These patients practically all survive - they are not sick and there is no reason for them to die. Result: all the patients died within 119 weeks, most much earlier as a result of panic and its conflict consequences.

There is a good reason why there should be a big question mark after all the statistics that report on supposedly positive or negative effects of cancer medication: they do not consider the law of the two-phases of disease! Neither psychologists nor medical statisticians were aware of the rule of right or left-handedness, the correlated connections of various conflicts, consequent brain localizations and the resultant organ manifestation.

For example: a left-handed, post climacteric, old woman who has a normal territorial conflict can suffer a cervical carcinoma that, in a young woman, could only occur with a sexual conflict (speaking biologically: of not being sexually fulfilled). This is almost impossible to explain to a psychologist today. The significance of not being aware of the meaning of left and right-handedness is a source of catastrophic errors for many statistically derived conclusions.

The biggest number of cancer statistics refers to the so-called carcinogens. These statistics are prepared as a result of experiments with animals. In so doing, the intelligence, the psyche and the specific biological brain code of the animals in question were never taken into consideration. This would have been necessary in order to answer the following questions:

- How can the experiment situation confronting a research animal involving the exposure to a given substance provoke a DHS?
- What kinds of products is such an animal exposed to in its natural environment?
- Isn't the very captivity of the research animal, usually involving dismal conditions, not in itself a conflictive factor that must distort any experimental design?
- To this one must add the complex of questions relating to the applicability of the experimental results to the human realm.

The carcinogenous nature of formaldehyde is unquestioned worldwide as demonstrated by the following research: American researchers sprayed rats - whose nose is their most sensitive organ - with a solution of formaldehyde used for disinfecting and normally given a wide berth by animals. The solution was concentrated a thousand fold and administered to their noses several times a day for a year. Some of these poor, horribly tortured animals suffered an obvious DHS as a result of this procedure and developed a nasal mucosa cancer. One could have achieved the same results with human research by spraying excrement into the subjects' noses every day for a year. The harsh conclusion would have been: shit is carcinogenic!

Enormous consequences were generated by the mass hysteria resulting from the formaldehyde research.

In my work '*Krebs und Rauchen*' ('*Cancer and Smoking*') HP-Journal 8/1983, I cited W. Dontenwill et al. (*Zeitschrift f. Krebsforschung u. klin. Onkologie* 89, 153-180. 1977) [*Journal f. Cancer Research and Clinical Oncology*] who had already demonstrated in Hamburg that lung cancer is obviously not provoked by smoking.

In a large-scale experiment, thousands of hamsters were exposed to cigarette smoke, while the controls were not exposed. It was ascertained that none of the animals suffered a squamous epithelium bronchial cancer or a pulmonary (lung) nodule cancer and that the exposed animals lived longer than the controls. Following the criteria of the official medicine, the discussion around cigarette smoking and cancer should have ended with the conclusion that cigarette smoking does not cause cancer. However, the results were hushed up and were made relative: if laboratory mice (descendant of the house mouse) are exposed to cigarette smoke, some of them develop alveolar (lung) nodule carcinoma, which men and mammals suffer from a death fright conflict.

And so it was reported that, yes, even though smoking does not produce bronchial carcinoma, it does, without doubt, cause a few lung cancers. From then on, bronchial carcinoma was not mentioned in connection with smoking, but lung cancer was. This is the wonderful way in which statistics can be used to deceive. The point is this: animals have a psyche, just as we do. A human embryo can suffer a motor conflict while in its mother's womb if it hears something like a lion's roar (sound of a circular saw) nearby. It has an innate signal code for that.

A hamster is not disturbed by smoke because smoke does not exist in his underground burrows, so he has not developed a panic code. A mouse, on the other hand, becomes quite agitated by the smell of burning or cigarette fumes: in earlier times if a roof truss was burning, the mice ran out of the house with lightning speed, before anyone was even aware of the event. Mice have an unusually fine nose for the smell of smoke and an innate panic code, and they can suffer a death fright conflict with an alveolar carcinoma.
We can therefore save ourselves this kind of research in the future.

I could continue to criticise the pseudo-scientific use of statistics in medicine. I will allow myself to prognosticate that the future will look back on our collective age and regard animal experimentation as a disgrace and a testimony of our unspeakable ignorance.

The following observation has been made: it appears that only men suffer from bronchial carcinoma and because men smoke, carcinoma of the bronchi must come from smoking.

The NEW MEDICINE explains it this way: bronchial squamous epithelial ulcerative carcinoma is the organic correlate of a territorial fear conflict. Territorial fear conflicts affect only males (or masculine post climacteric women). Young women who are left-handed can also suffer bronchial carcinoma (together with depression). Given female hormones it does not usually get very bad and it is seldom diagnosed. None of this has anything to do with smoking.

In '*Scientific American*' (Spectrum of Science, 3.ed. Heidelberg 1990) I read with surprise how cigarette smoking and cancer are linked, i.e., specifically the assertion of a causal connection: a 'latency period' was created all of a sudden and a shift was made from bronchial cancer to 'lung cancer' (with alveolar cancer). The whole thing now read like this: 'Lung cancer is a disease of the twentieth century. In the beginning, only males were affected but in the meantime it has started affecting women as well. In the USA, lung cancer (men) is responsible for about one third of all deaths, in England for about one half. From the start it was believed that cigarette smoking was the likeliest cause since this was a new form of polluting the air to which men were first exposed and later women. This explanation encountered difficulties, however. It was impossible to correlate the incidence of lung cancer with the per capita consumption of cigarettes in different places. This problem was resolved with the recognition of the long incubation period of the disease (next Plate). Many questions remain open, yet the basic fact is no longer questioned: a cigarette smoker is ten to fifty times more likely to die of lung cancer, the exact risk dependent on the amount smoked and on where he lives. If a lot of people in a group give up smoking, the mortality rate for lung cancer within this group will be reduced. This gives the impression that lung cancer, the deadliest form, could be reduced overall if smoking were reduced .

How could such statistics and conclusions have come about? It is quite simple: three factors had not been considered:

1. The 1920's saw a worldwide economic crisis and mass unemployment, no welfare, no unemployment benefits, a great fear of death during and after the First World War, and liver and lung cancer were very common.
2. The eradication of contagion by tuberculosis since the 1930's was celebrated as an outstanding achievement of modern hygiene. Although there was a reduction in liver and alveolar (lung) nodule carcinomas in the thirties because of the much improved economic situation, those that arose after 1939 in much higher numbers because of the war, were no longer caseated by tuberculosis and remained visible to diagnostic exploration as alveolar (lung) nodules, i.e.,' lung cancer'.

I quote W.E. Müller (*Die Infektionserreger des Menschen*, 1989 S 3) [*Infectious Germs in Humans*, 1989, p.3]: „In 1850, the mortality rate from tuberculosis in Northern Europe was still about 50 times as high as it would be 50 years later."

Deaths from tuberculosis in the USA for every 100,000 inhabitants in the year

1900 : 194
1940 : 46
1956 : 8

(Dokumenta Geigy, wissenschaftliche Tabellen,1960. S.632) [Document Geigy, Scientific Charts. 1960. p.632]

16.1.3 Tuberculosis

There is an interesting work on tuberculosis by Citron and Girling (D. Varrell, *Lehrbuch der InfektionskrankheIren*, 1990).[D.Varrell, *Textbook of Infectious Diseases*, 1990] from which I will cite some interesting points: „Animals can be injected with a great number of tubercular bacteria without necessarily having a pathologic reaction. The exact mechanism of their virulence is not clear." A very long attempt at an explanation follows, whereby all the cellular-pathological possibilities - phagocyte hypothesis, immunological hypothesis, T-lymphocyte hypothesis - are exhausted. The brain or the psyche, of course, is not considered.

And yet, medical historians have noticed that tuberculosis and poverty are always related: „...In Great Britain, the epidemic of tuberculosis during the industrial revolution of the nineteenth century claimed so many victims that it became known as the 'white plague'. The incidence of the disease later steadily declined, even in the absence of control measures. The cause probably lies in the reduction of risk of infection, much better living conditions, better nourishment and better social conditions, all leading to a better host resistance." Later one reads: „...In most developing nations, the present risk of tuberculosis infection is 20-50 times as high." (to complete the sentence: ... as in Great Britain).

With this in mind, I want to say that the right facts were collected. The facts are not in dispute. However, the fact that tuberculosis has something to do with fear, specifically the fear of death, and especially among the poor, was not observed by anyone. This was probably because so-called serious doctors were always rich. They were unable to place themselves in the position of the poor. Had one ever tried it, he would have discovered the first phase of lung tuberculosis at once, and so would have co-discovered the whole of the NEW MEDICINE as well.

During the following period, more and more alveolar (lung) nodules were diagnosed as lung cancer, which would earlier have only been diagnosed as tuberculosis during the PCL-phase. This is how tuberculosis decreased and lung cancer increased.

Cigarette smoking and lung cancer are undeniably related. Because of the great time lapse between the increase in consumption of cigarettes and the higher incidence of lung cancer, the relationship was obscured for a long time. The dates shown are from England and Wales. The incidence of smoking among males (black symbols) increased at the beginning of the 20th century. However, the corresponding increase of cancer deaths was not observed before 1920. Women (coloured symbols) started smoking much later. Lung cancer is only now on the increase.

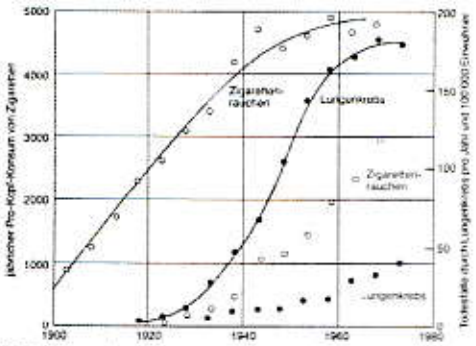


Plate itself:
[left] yearly per capita consumption of cigarettes
[right] incidence of death from lung cancer per year per 100,000 inhabitants
[first curve left] cigarette smoking
[second curve middle] lung cancer
[third curve middle] cigarette smoking
[fourth curve right] lung cancer

16.1.4 Bronchial carcinoma was re-named lung cancer

(vgl. 'Spektrum der Wissenschaft' wie oben, S.18) [compare ' Spectrum of Science' as above, p.18]

The above comparative graph diagrams are very informative: their sense and purpose is very clear, demonstrating at all costs that smoking does cause cancer. The investigations by Dotenwill et al.: '*Untersuchungen über den Effekt der chronischen Zigarettenrauchinhalation beim syrischen Goldhamster und über die Bedeutung des Vitamin A auf die bei Berauchung gefundenen Organveränderungen*', Z. Krebsforschung 89. 153-180 (1977) ['*Inquiry into the effect of chronic cigarette smoke inhalation on Syrian Hamsters and on the significance of vitamin A on the organ changes found after forced smoke exposure*'] are facts: of 6,000 hamsters exposed to a whole life of smoke, not one animal developed bronchial cancer and not one developed lung alveolar cancer. These facts are being made to fit the statistics in order to be able to come to the conclusion that smoking nevertheless causes cancer. This result is arrived at with recourse to several hypotheses that make it plausible:

1. Bronchial cancer will no longer be considered; the name has become 'lung cancer'. However lung cancer is:
   a) Bronchial ulcerating squamous epithelium carcinoma always discovered in the PCL-phase as 'atelectasis'.
   b) Alveolar adeno carcinoma, also named pulmonary (lung) nodules, which is detected in the conflict active phase. In the PCL-phase, if acid-fast rod-shaped bacteria are available, this becomes lung tuberculosis.
   c) Intra-bronchial goblet cell adeno-Ca, evident only in the conflict active phase or when no acid-fast rod-shaped bacteria are available in the PCL-phase. Should this particular bacteria (tbc) be there, the (very small) Ca caseates as tuberculosis.
   d) Mesothelioma of the pleura, which is not commonly noticed in the CA-phase, in the PCL phase with tbc: Pleura tbc, thickening of skin; without tbc, so-called carcinomatoid pleural effusion.
   e) Mediastinal pharyngeal-arch-duct ulceration, retrocardial, squamous epithelium ulceration. In the PCL phase, pharyngeal arch duct cysts. With several relapses there is induration of the so-called centrocytic-centroblastic. Non-Hodgkin's lymphoma.
   f) Retrosternal euthyreote, mediastinal, precardial thyroid-duct-squamous epithelium (only in the PCL phase) struma.

The hypothesis is that all of these tumors have something to do with smoking. Yet the cigarette smoke only reaches as far as the bronchi, practically not even into the alveoli. Not knowing about the second biological law, the 'tumors' are not even defined. The CA-phase tumors are confused with PCL pseudo tumor remains from impeded Tbc caseation and Tbc itself. The results can only lead to confusion!

1. The connection between cancer and tuberculosis is not considered. Oddly enough, no one has noticed that with the decline of Tbc, there has been an increase in pulmonary (lung) nodules. In India, for instance, (c.f. next illustration) there are fewer than 25 'lung cancer' incidents per 100,000 inhabitants. In Europe, on the other hand, it is up to 100 cases (valid for men). However, India has 20-50 times the incidence of lung tuberculosis.
2. A hypothetical period of latency is arbitrarily constructed, as if it took 20 years for the effect of cigarette smoke to become effective. This trick allows the holding of today's unexplainable facts at bay for a little while longer, since they only need to be

explained in twenty years. Back to our diagram: while the increase in lung cancer between 1920 and 1940 is quite possibly tied firstly to an improvement in X-ray diagnosis and presumably includes cases of bronchial atelectasis, from 1940 on there were improved diagnostic techniques and suppression of tuberculosis. It is curious that the graph stops around 1970/72, because additional phenomena can only be explained with difficulty. The consumption of cigarettes dips from 1970 on, and so-called lung cancer should also have gone down if smoking caused it, but this is not the case.

Another error is the failure to consider the age pyramid. Old people suffer a much higher incidence of bronchial cancer and pulmonary (lung) nodule carcinoma than the young. We only count the incidence of lung cancer in a given population unit in a given time unit, even though there has been a significant increase in life expectancy and we simply say that it has increased. For the mass of those between 65 and 85 we have an insignificant group to compare with!

16.1.5 The 'questionnaire statistic'

I am very wary about results of so-called 'questionnaire statistics' when a question such as „Have you, within a given time span, had a psychological-biological conflict?" is asked of a patient in a group. As we know from the NEW MEDICINE, the trigger for a DHS with a biological conflict does not have to be the 'loss of a partner'; what is relevant is the WAY in which the loss occurred and how it UNEXPECTEDLY affected the individual. This is what decides whether there is a biological conflict.

On the basis of knowing the five biological laws, we can assume that most statistics regarding psychological data on patients are completely worthless, in particular if such falsely obtained data is used to refer to the incidence of disease.

For non-smokers, 'second-hand smoke' was fabricated, containing more than 1200 different substances that can occur in all sorts of other materials and chemical combinations that we all inhale.

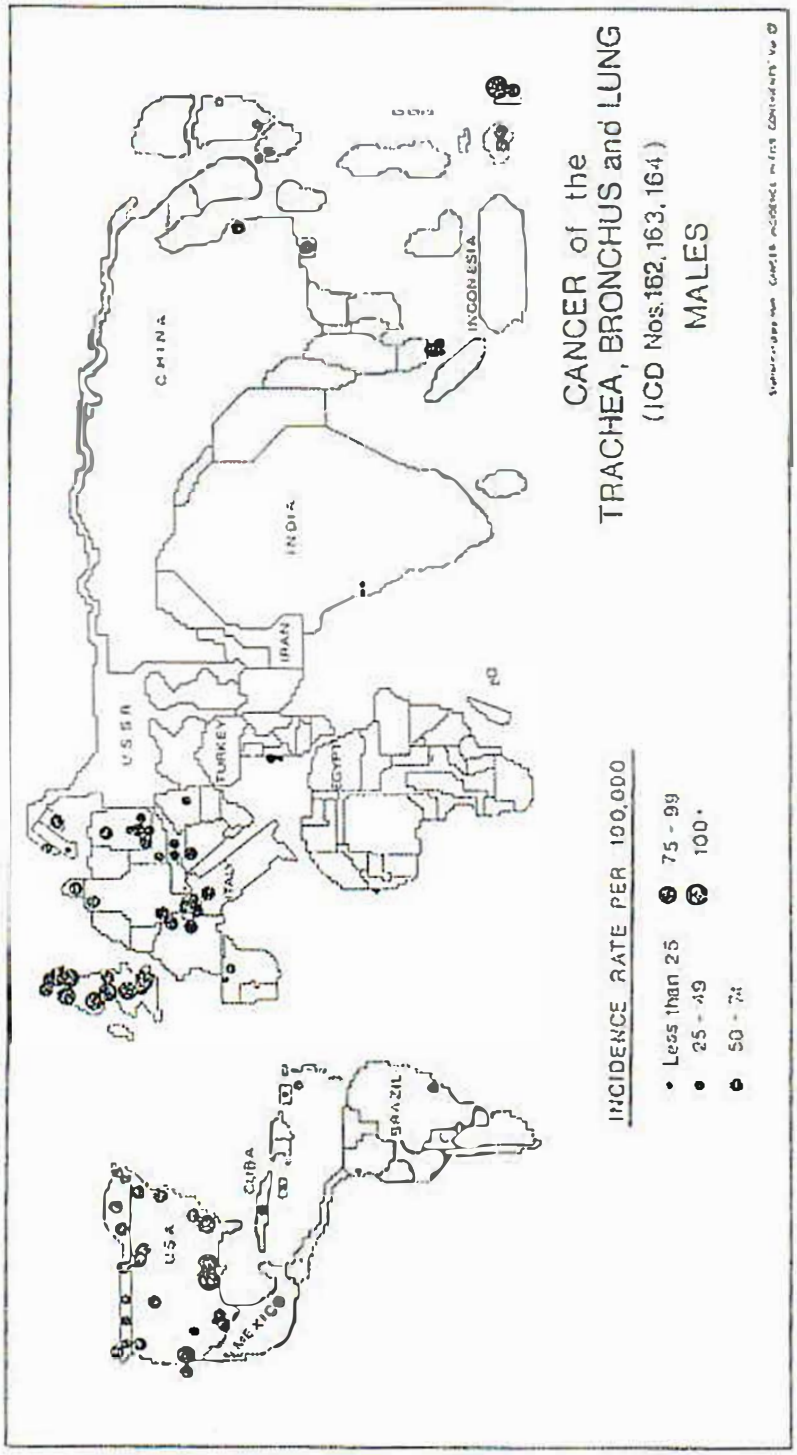


Fig. 1.3 Cancer of the trachea, bronchus and lung: global incidence 1973–77: males. No comparable data available for the blank areas shown on this map and on Figs. 1.5, 1.7–1.9, 1.11, 1.13–1.15, 1.17, 1.19, 1.21 & 1.23–1.24.

16.1.6 The 'Success case statistic'

I am often asked by all sorts of physicians to document 'success cases', my 'best cases'. If we were all to take our best twenty cases, we would all be equal. It would not make any difference if ten other practitioners also produced well-documented cases, each believing that it was their therapy or their treatment that had worked.

There is no success or failure in a scientific-biological system. The system is pre-programmed when it is based on the biological laws. Regardless of therapeutic intervention, everything will follow the five biological laws.

17 The connections between psyche-brain-organ that were already surmised before 1981

17.1 A historic retrospective

People have always felt a connection between psychological conflicts, emotions, traumatic experiences and shocks in life, such as the death of a partner or a child. Our language provides a testimony to this in countless phrases and expressions. The following expressions briefly illustrate how closely people have approximated an understanding of biological conflicts in the sense and content that I myself have understood them:

Describing the experience of shock, the DHS:
It was as though I'd been hit by lightning
It hit me like a blow
It went right through to my very core

Ongoing conflict activity:
I've never been able to get over it
I couldn't swallow it
I battled with this problem for a long time
This is going to get the better of me
I still have sleepless nights about it
I can't get over it

Brain level:
My head can't tolerate it
My head is bursting

Archaic morsel conflicts, e.g. tonsils:
Not being able to assimilate something
Not being able to grab something
To want to collect something

Indigestible gastro-intestinal conflict, indigestible anger:
Somebody could not stand it
I haven't digested it yet
It's lying in my stomach

Existence conflict, kidney-collecting tubules:
It went straight to my kidneys

Fright conflict, area of the larynx:
It left me speechless
I was speechless with horror
It took my breath away
The words stuck in my throat

Fright-fear conflicts, regarding larynx:
I was struck dumb
I was speechless with terror
It took my breath away
The words stuck in my throat

Fright-fear conflicts, with motoric conflict components:
I was frozen with terror
I turned into a pillar of salt
I was paralysed with fear
I didn't know whether I was coming or going
I was trapped
It was as if I was rooted to the spot

Sexual (female) (male sexual) territorial conflict affecting the coronary vessels:
It breaks my heart
It makes one's heart bleed

Territorial anger conflicts, liver-gallbladder, stomach area:
With such anger he spat poison and gall
A louse ran over my liver (anger)
It struck me in the stomach
Green and yellow with anger
Sick to death with anger

Fear-from-behind conflict, affecting the visual cortex:
Unable to shake a problem
The problem, danger, is looming over me
Thoughts about it still pursue me

Self-devaluation conflict, concerning bones:
Breaking someone's back
Not being able to withstand something - i.e., standing

Stink conflict, affecting the nasal mucosa:
This stinks!
I'm really fed up; I've had enough!

Hearing conflict, tinnitus:
I can't believe I heard that
It's still ringing in my ears

Separation conflicts concerning skin, eyes and others:
Losing sight of someone
To be torn apart
Contact broke off

Only in the twentieth century is this knowledge lost to physicians and scientists. This is truly amazing because in many ways, there had been an enormous convergence towards the core of the subject.

These expressions indicated a general and overall vague approximation; only a system was missing, and yet the correlation between the psyche and the origin of cancer had moved much closer together than in the twentieth century, with its fixation on physiological procedures and investigation of facts at the body level.

In ancient Greece, it was the priests of Aesclepius who dealt with psychic conflicts. They would ask questions about the previous night's dreams and on that basis come to conclusions about the psychic problems and physical diseases of the people looking for answers. In the second century A.D., the Roman physician Galen made the observation that cheerful women tended less towards cancer than melancholy women.

Many of the world's peoples have probably had a similarly intuitive understanding of disease. In all likelihood, the Indians of North America had this knowledge, although it

was not passed on to us. Even in the nineteenth century, many doctors believed that cancer resulted from a blow of fate. The English physician, Gendron, in his treatise published in 1701, '*Enquiries into the nature, knowledge and cure of cancer*' wrote that: „... cancer was caused by a misfortune occasioning much worry and travail." His case studies came very close to the correlation between conflict-shock and cancer.

This knowledge found even clearer expression in a book published in 1846 by Dr. W.H. Walshe '*The Nature and Treatment of Cancer*'. Even the discovery of the real trigger, the shock experience (DHS), is indicated when he mentions the moment of the unexpected: „Much has been written about the influence of emotional pain, unexpected reversals of fate or a melancholy temperament on the transmission of carcinogenic substances. To the extent one can believe the systematically preceding authors, these manifestations constitute the most influential cause for cancer ... one could make very convincing observations regarding the influence of the mind on the development of this disease. I myself have had to do so with cases where the relationship was so obvious ... that to have questioned it would have meant to go against the dictates of reason".

Although not the subject of this thesis, we must seriously ask how physicians have lost this knowledge.

H. Snow systematically investigated these connections at the London Cancer Hospital, examining 250 outpatients and inpatients with breast or uterine cancer. He concluded in his 1893 book '*Cancer and the Cancer Process*' that of those patients, over 200 had reported experiencing emotional problems, suffering and confusion before their disease.

He concluded: „Of all the causes for cancer development, in every shape or form, the most powerful are the neurotic agencies; the most frequent among the predominant causes is emotional pain. Exhaustion and deprivation are the next. They belong to the immediate cancer-generating causes and importantly predispose and influence its further development. Oddly enough, the feeble-minded and the mentally disturbed rarely have cancer".

This knowledge gradually faded during the twentieth century and attention focussed on surgery, anaesthesia, radiation therapy, etc. Oddly enough, it was around the time of Freud's psychoanalysis that natural reactions to the blows of fate were lost. No one could or would seriously test the observations made by these intelligent doctors of earlier centuries. It is amazing how purposefully the goal was avoided.

The map showing the formerly assumed relationship between the brain and cancer is presently blank. There were areas in the brain not discovered by me that had been known for a long time - the so-called homunculus, for instance. This homunculus had to be unequivocally related to the motoric cortex, the pre-central gyrus of both cerebral hemispheres, the sensory cortical centre in the post-central gyrus and the visual cortex.

This means it was not known exactly which area of the visual cortex was associated with which part of the retina, but it was understood that disturbances of vision at the retinal level also involved the visual cortex. There were many connections and innervations that had long been established between certain organs and the motor and sensory cortexes. The areas of the brain that controlled the striated musculature of the right leg, or the right back or the right greater pectoral muscle were identified, as were the control relays for skin sensitivity in the sensory cortex of both cerebral hemispheres.

Difficult as it is to believe, this knowledge was lost again as neurologists kept looking for MS in the medulla, even though the brain CT's and MRI's showed the 'demyelination foci' and small plaques or glial thickening, thought to be the cause of MS. Of course, they were wrong. The truth is that patients have motoric paralyses because of repeated conflicts of self-confidence. If they become used to their paralysis and resolve or compensate their

conflict, glial foci in the medulla are found as the leftover results of the bone relays in the medulla. We can also confirm that MS does not exist in the sense it was previously understood. In the NEW MEDICINE today we talk of sensory or motoric paralysis that can be assigned precisely to the homunculus in the motoric and sensory cortical centers.

We also did not know what was innervated from the large postsensoric cortical centre. I believe I have discovered this, and it is the periosteum or, more precisely, the sensory nerves that lie on the periosteum which were originally embedded in squamous epithelium mucosa but later, having no function, became superfluous and regressed. We still see this squamous epithelium in the third and fourth week of the embryo. The corresponding biological conflict (c.f. chart) is a 'brutal separation'.

We can therefore say that up to now we knew only of a few connections between the brain and the organs.

17.2 Separation from Psychology

Sigmund Freud, the founder of psychoanalysis, developed an encompassing theoretical system regarding the causes and elimination of psychological disturbances. He could not connect his theories (libido and sexual) to either the brain or the organ level, so experimental proof had to be silenced. Thus, observations that were largely accurate (regarding the unconscious) became mixed up with half-truths and completely false explanations for both Freud and his disciples. The psyche ends up as something altogether separate from the brain and body, ingrained through experience from the infant stage, yet understandable only through complicated theories.

The archaic biological conflicts overlap with these long, drawn out psychological conflicts only in the marginal sense as hanging conflicts. The biological conflicts are totally different, so we only seem to be talking about the same thing when psychologists speak of the psyche or of a conflict.

The following comments are valid for most psychological positions taken:
Until now, no one had looked for an acute conflict or anything remotely like a DHS; neither had it been relevant to scientifically research the specific impact of acute, dramatic, conflict-experiential shocks and the particular observations the patient made at that precise moment. It was believed that conflicts had a long history and development period and that the patient's life would provide the reasons for them and for any disturbances. Biological conflicts have no 'pre-history'; they may exist in a psychological sense in many cases but, for instance, in the diagnosis of a water conflict (e.g. a boating accident during a thunderstorm), the patient's history is comparatively uninteresting, or, more precisely, irrelevant. Psychological and biological conflicts are completely different, even if they sometimes overlap. We must always remember that animals, too, suffer biological conflicts!

In psychology, many events are not considered to be conflicts. For instance, what counts as a 'conflict' in the psychological sense is the loss of a relative or the break-up of a marriage. The possibility that a mere word (like 'pig') could manifest a cancer, e.g. biological conflict, seems most unlikely. What I have said about conflicts having to be acute, dramatic, unexpected and catching us on the wrong foot, has so far been ridiculed.

I have already mentioned the patient who lost four close relatives (father, mother, brother and uncle) but did not suffer a single biological conflict because she knew that none of them had a chance of surviving. However, the uncle had promised to leave her his wonderful chest. In his will, however, it was left to her sister. The patient snapped and suffered a biological conflict, because this caught her totally off-guard. She came down

with pancreatic cancer. Although I have discussed this case in another chapter, it clarifies matters very well.

No one would have been able to see the connections for that particular cancer from the actual event since they were not able to differentiate between the conflict-active stress-phase, with its own symptoms, and the conflict-resolved vagotonic phase. The psychic 'values' for both phases are, of course, completely different! The criterion of cell-multiplication in cancer, as in cancer of the intestines, ovarian tumors, (cysts) or osteosarcoma, caused the diagnosis of totally different disease stages and manifestations to be examined for a possible common denominator, which it could not have, because of the ignorance of the ontogenetic system of tumors. There was also no distinction made psychologically between primary and consecutive diseases and fully cured, old carcinomas, discovered by accident. That is why many of the results of these investigations are absurd.

Something very important has to be added: according to our present understanding of the NEW MEDICINE, general psychotherapy of the patient must not occur because he must resolve his innate biological conflict in a biologically real sense. The additional 'power' a patient gets from the active biological conflict through the sympathicotonic stress-innervation has been designed by nature to give the patient an energy boost to help him with a conflict resolution. Practically all psychological therapies are wrong in that they disregard the essence of the matter and fail to understand the mechanism, but attempt to rein it in, block it or stop it. I want to explain further that this stage requires great care.

We must discover exactly when and precisely how the DHS occurred, what phase of which conflict we are in and develop with the patient what I call an individual, specific and procedurally appropriate biological therapy. Psychologists are not adept at these psycho- and organ-detective approaches because they lack the medical-biological backgrounds. This deficiency on the part of many psychologists can mean the death of the patient in extreme cases as, for example, those cases where all conflicts are enthusiastically solved without regard to their duration. For instance, if a territorial conflict of many months' duration is resolved, thanks to the efforts of a well-meaning psychologist, at the height of the healing phase we have the epileptoid crisis which can be expected as a heart infarction. This is totally unexpected for all parties, not unusual and might be fatal, as I have already experienced a few times. The same is also true for other conflicts of long duration that are resolved through ill-advised therapy, as they can produce powerful brain symptoms such as headaches, brain pressure, edema, etc.

There are many long-term conflicts that should not, under any circumstances, be resolved, as the patient would not survive the healing phase. If he remains in conflict activity, however, he can lead a relatively normal life, apart from the fact that he may always be as thin as a rake and in constant danger of a schizophrenic constellation (with the cerebral conflicts).

The NEW MEDICINE could have been discovered from many angles - the embryology of the germ layer particularities of the individual organ groups or from histology - had anyone reflected on the fact that it contains a system when we compare the correlated organ groups. It could also have been discovered from (the study of animal behaviour) behavioural research or from the localization of the brain relays that are correlated to organ groups, as we already knew from the homunculus.

The death of my son Dirk, the consequent conflicts and my experience with cancer all contributed to setting me onto a certain path because I was a clinician (with a body and soul). As if driven by compulsion, my confrontations with psychologists and, to a lesser extent, with psychosomaticists, followed.

I still remember a radiologist in our clinic in Oberaudorf who had studied a few semesters of psychology. When I gave a lecture to my colleagues and tried to explain that, according to my observations, acute-dramatic conflict-shocks had caused the cancer, he groaned, „That's all nonsense and doesn't exist in psychology". Fortunately, with several years of experience in neurology and clinical psychiatry behind me, I reacted with complete indifference. It is not reality that has to adjust to psychological theories, but the other way round. To the degree that medicine wants to be taken seriously from a biological and scientific point of view, using experiments as the basis for all future analysis, to that degree will psychology lose its grip, disadvantaged by its theoretical constructs which do not match reality.

On the whole, the basic shortcoming of psychology is that it not only lacks medical knowledge, but medical experience as well, and this should be codified in psychotherapeutic law. Parallel to this, as the new psychotherapeutic law is set in stone, physicians will see themselves more and more as organ-doctors. They leave the psyche to the psychologists. However, as we have seen so far, we cannot split the individual into separate parts.

E. Evans, 1926 and LeShan tried to provide therapy for cancer patients through their 'personal development'. The attempt to '*Understand the malformation of the patient*' (Mars, Fritz Zorn 1977) led to adventurous speculations by therapists as they tried to provide 'therapy' for a patient who had malignant lymphoma with the result that they made him sick again, since malignant lymphoma is in reality a harmless swelling of the lymph nodes in the healing phase. We can see doctors, psychoanalysts and psychologists working past each other indifferently, with the psychologist accepting the physician's diagnosis at face value and passing it on. There was a hypothetical assumption (Engel 1954, Grinker 1966, Bahnson, 1966, 1969, 1979, Baltrush 1975, Schmale 1977, Fox 1978) that cancer was to be understood as a result of pre-morbid psychosocial influences and the personality of the cancer patient.

Engel (1961) examined the influence of loss and grieving on cancer, and defined loss as the loss of a precious object, a close relation, a property, a place of work, one's home, one's country, ideals, body parts, etc.

Such investigations are typically psychological and have little to do with biological conflicts. The biological realm is such that a loss conflict can only be experienced for another human or for an individual of the same species. Even here though, it depends on whether, in the second of the DHS, the conflict was experienced as a loss conflict or as a territorial conflict (inheritance, pecking order) or not even experienced as a biological conflict if the death was expected. On the other hand, if the loss happens during an argument, a woman could develop breast cancer instead of ovarian cancer. If the loss is experienced as a separation conflict, the result will be a biological conflict with a sensory function loss or (depending on whether it is for a child, a mother or a partner) left or right breast ductal ulcerating carcinoma, which is practically undetectable in the conflict active phase. The side affected depends on whether the woman is right or left-handed. If the loss refers to a home, specifically one's own home, the corresponding biological conflict can be a territorial one; but it could also be a refugee-conflict with carcinoma of the collecting tubules of the kidneys in the CA-phase. If the patient loses not only his house but also his possessions, he could suffer a biological starvation conflict, but always, of course, with a DHS.

As can be seen, worlds separate us! Even for animals, the loss of a 'morsel' is completely different from the loss of a close member of its species.

Investigations in the psychological field into whether grief is an illness (Engel 1977) and whether or not, if not processed, might turn into 'helplessness or hopelessness', are

psychological questions of a purely speculative nature that have nothing to do with biological realities.

Normal grieving for the death of a close relative is, of course, not an illness but a very natural reaction. If, however, there is a DHS with a territorial conflict and a hormonal imbalance, this becomes a territorial conflict with a true depression. A young left-handed female can suffer this same symptom at the time of a DHS with sexual conflict contents. Helplessness and hopelessness are, on the whole, concepts describing a person's outlook which are not biologically relevant, even though one can incorporate them, to various degrees, in the understanding of a depression.

To re state: all these psychological investigations and their apparent or real results are irrelevant in the biological sense.

Another example that could be interesting in this connection: Green (1954, 1956, 1958, 1966) investigated 132 patients with leukaemia and swelling of the lymph nodes. He believed that these diseases began when the patient had to come to terms with many losses and separations and, as a consequence, ended up with fear, rage and hopelessness. Leukaemia, in the NEW MEDICINE, and lymphoma, are demonstrably the PCL phase of a self-devaluation conflict on the organic plane, where they are preceded by bone osteolysis and lymph node necrosis. Of course, in this PCL-phase the patient has intense periost pain which the psychologist might interpret as 'rage'; the patient feels tired and worn out, which the psychologist might interpret as 'hopelessness'; but otherwise he feels well, has a good appetite and sleeps a lot, as long as he is not brought back into a panic, which the psychologist might then interpret as 'fear'. As a non-medical practitioner, the psychologist is unable to distinguish between vagotony and hopelessness. But one must allow for the fact that the patients he sees are all caught in the mill of chemotherapy and therefore subject to repeated panic attacks and the toxic effects of cytostatic drugs.

One of the best-known epidemiological studies states that Japan has the lowest breast cancer rate of the big industrial nations. However, when Japanese women emigrate to the United States, they suffer four times as much breast cancer but a much lower incidence of stomach cancer. It was always argued that the reasons for this were racial or food, but no one believes that any more today.

Research into the connection of cancer and stress usually confuses cause and effect, given the fact that all patients in the CA-phase are in long-term stress innervation.

Finally, I would like to briefly present the differences between the NEW MEDICINE and a psychological approach to understanding cancer following the example of L. LeShan, Stuttgart 1993.

The author is a psychotherapist who comes to the conclusion, based on 500 interviews with patients declared incurable, that they all have certain personality traits that make them susceptible to the development of the disease. With our understanding of the NEW MEDICINE, we know there are bound to be distortions in these findings because the patients interviewed are all likely to be suffering an abundance of conflicts and related cancers.

LeShan's goal is to find a definite 'cancer-personality'; in this he is certainly going too far, since the personalities of most cancer patients only start showing common elements during the course of therapy and prognosis, not before the development of the disease.

„The person attacked by cancer has a psychological orientation which makes the development of the disease more likely, and when he has a malignant tumor, it (further) impedes the fight for his life." (p. 13) Of the patients interviewed who survived his therapy, it is significant that they were almost all patients with lymph gland cancer,

Hodgkin's disease and brain tumors; according to the NEW MEDICINE, all in the PCL-phase.

Typical of the psychological point of view is the following conclusion: In answer to the macabre question: „What do you really want to do with your life?" many of the cancer patients stared at LeShan in astonishment. He concluded from this that patients had an inability to aggressively express their own requirements, wishes and feelings. I suspect that these are likely to be secondary phenomena, for I never see this hopelessness and lack of faith in patients before their disease. I think that talking about a 'cancer-personality' is a disastrous mistake. Occasionally, sympathicotony or vagotony, which profoundly affects the psychological state of a patient, will suggest a psychological portrait reminiscent of the foregoing.

LeShan certainly created awareness for the existence of psychic reasons for cancer, but did not reach the core of the matter because he did not differentiate between totally different conflicts and only saw causes in a very generalized view of the patient's pre-history and personal development. Needless to say, he had no interest in cerebral or organic events.

17.3 Separation from psychosomatics

My professor from Giessen, Thure von Üxküll, for whom I was resident (physician), wrote a very thick classic on psychosomatics. It deals with the question of sympathicotonia and vagotonia in a few short lines stating that these disturbances entail 'vegetative dystonia'. Psychosomatics was certainly headed in the right direction and even arrived at many correct conclusions. It would be unfair to many authors not to recognize their attempts to establish correlations between psyche and organ. However, one cannot really work with them because unequivocal and sturdy connections - such as the NEW MEDICINE lawfully exhibits - were never found.

From the very beginning, psychosomatics dealt only with diseases where a conflict had allegedly become chronic, causing somatic changes in the organs via the vegetative nervous system. In order to find out what these conflicts leading to a particular disease might be, it normally uses psychoanalysis. It is no wonder that the search to connect certain disturbances with definite conflict constellations has been in vain. Granted, uniform rules for the selection of organs had yet to be found.

An asthma attack was typically seen as an outburst of tears, high blood pressure corresponded to an attack of suppressed rage, and stomach ulcers were the result of a constant conflict between aggression and a tendency to escape. These examples show how far removed psychosomatics is from the NEW MEDICINE.

Unfortunately this resulted in the psychosomatic approach bringing its practitioners too close to the wake of the psychologists instead of keeping them in the realm of biology and the behavioral analysis of primates.

There were constant discussions about stress potentials and stress research, but no observations that stress was merely the consequence of a DHS, a symptom of the CA-phase. The popular books on psychosomatics (Brautigam, Christian, vom Rad) do not even refer to the term sympathicotonia. Perhaps I am too scientific for the vague psychosomatic approach. I think psychosomatics will not have a place beside the NEW MEDICINE but it will be supplemented with hard, biological rules and absorbed into it.

Grossart-Maticel (*'Disease as Biography'*, 1979) complains about the psychosomatic cancer researchers: „So far, scientists have not been able to develop a method to differentiate between the psycho-social conflicts before the disease and the psycho-social

changes after the onset of the disease. This was not possible in the individually conducted studies, since the shortcoming lay with the investigative approach."

Grossart-Maticek understands one aspect correctly, that after the diagnosis one could distinguish quite clearly what was there before and what was released by the brutal punch of the diagnosis itself.

One of the things he doesn't see, understandably, since the biological laws of the NEW MEDICINE were not known, is that the patient is either in a conflict-active standing sympathicotonia of a psychological kind in order to resolve his conflict, or, he is in a standing vagotonic healing phase, because he must regenerate his organism. They can both only be understood biologically, not psychologically or psychosomatically.

17.4 Separation from psycho-oncology

Preamble:
I find it difficult to find intellectual predecessors, even if only in specific considerations. I have been criticized for not citing any authors who have already commented on the suspected connections between cancer and the psyche.

Every finding and discovery builds on known facts, seen as part of a developmental sequence of prior scientific achievements. However, the linking of these facts, which have only been collected but not ordered into an easily reproducible synopsis corresponding to any case, is new.

In 1981 the concept 'psyche' did not even occur in the index of standard works on tumors. That is because investigations were dominated by attempts to find cancer-causing agents and the belief that a number of carcinogenic substances had already been found. The possibility of a psychogenic origin disappeared from consciousness. In fact, in conferences and similar events, it was suggested that this kind of potential causation lacked seriousness, and provoked irony and derogatory laughter. On the other hand, theories emphasizing the biological-mechanical-tumor origins were very popular, one being the so-called paraneoplastic syndrome that for years was believed to be the origin of cancer manifestations.

I was obliged at the time not to mention the name of the clinic attached to the university in which I had completed my first systematic examinations, because my findings were considered, *a priori*, irresponsible.

At the end of 1981, after publication of my findings, a little book appeared by Meerwein/Adler: '*Introduction to Psycho-Oncology*'. The first printing regarding the psychogenic origin of cancer read: „The idea that cancer is a regressive attempt at regeneration on the biological level because of fatigue, i.e., blocking of psychological expression, is one-sided and lacks understanding of the biological complexity of the problem". The second edition, however, read as follows: „The idea that cancer is a regressive attempt at regeneration on the biological level because of fatigue, i.e., blocking of psychological expression, is fascinating, but we believe that the present knowledge in psycho-oncology does not allow for an encompassing explanation."

The NEW MEDICINE has nothing to do with psycho-oncology. (Think of the possibilities of psycho-ophthalmology, psycho-orthopaedia, psycho-gynaecology, etc). The NEW MEDICINE is a system based on five biological laws encompassing all of medicine, and in no case is a psychological hypothesis-theory for cancer.

So-called psycho-oncology does not question the accepted cancer treatment methods of the current official medicine.

There is an interesting study by Ulrich Abel, Heidelberg, head of the department for oncological statistics, entitled '*Cytostatic Chemotherapy of advanced epithelial tumors*'

(1990). He writes about so-called epithelial tumors and includes everything except lymphomas, leukaemia, sarcomas and germinomas (germ cell tumors): „Other than in the case of bronchial carcinoma (especially small cell), there is no evidence that chemotherapy prolongs the life of these patients". He writes in the foreword: „However shattering the result of this work may be, it is the singular conclusion of this undertaking, based on the unprejudiced and all-encompassing evaluation of the relevant literature ... Even the objections directed by official medicine towards 'outsiders' in the medical field, although frequently appropriate, fall back on themselves because they are not in a position to support their claims of success in a scientific manner. It is urgent to re-think cancer therapy and cancer research, not only on scientific grounds but also from the point of view of the patient."

Finally, I would like to comment on the first exponent of psycho-oncology, O.C Simonton: '*Getting Well Again*', 1978; (German edition: O. Carl Simonton, Stephanie Matthews Simonton, James Creighton, '*Wieder gesund werden*', 1993). Simonton is a radiologist and specializes in radiation-therapy; he ostensibly does not want to replace the current medical treatment, but only to complement it.

He starts from the patient's 'will to live', claiming that the rate of survival depends on and is measured by the degree to which the doctor's instructions are followed (obedient patient!). He uses a motivational psychology technique which is supposed to strengthen the will to live, as well as bio-feedback methods of visualization, described as follows: „In the case of a cancer patient, he should try to visualize pictorially the destruction of the cancerous growth through the therapy but especially through the natural defence mechanisms of the body in its fight against cancer". Visualization, therefore, ultimately becomes the companion of radiation therapy, etc. On the whole, the patient has to create very material images of the processes in his body (a battle) (compare p. 13 ff).

Unfortunately, such images are typical and lead the patient further away from an insight into the true relationships of his disease. If the conflict is not resolved, the visualizations, however aggressive they may be in the battle against the bad cancer cells, are to no avail.

Simonton, at least, is interested in the psychological problems of his patients who, in the new edition of his book (sic!) have already been re-settled as early as six to eight months before the onset of their disease! To his credit, he states that all statistical surveys of the cancer phenomenon are hampered by the fact that „psychologists have no physiological data and physicians have no psychological data for their examinations!" From the perspective of the NEW MEDICINE, Simonton's omission, like Leshan's, is his failure to consider the cerebral level of the cancer event and he clearly does not concern himself with other diseases in connection with the psychological influence factors.

18 The biological unity between man, animal and plant. The self-sustaining cosmos. Concluding thoughts

In the natural sciences and in biology itself, the rule is first to gather reliable facts and then look for reproducible combinations of these facts. This will lead to the phenomenon that humans, animals and other organisms are organized in very special units related to each other. One could say that they are networked. This is particularly clear with man and animal in the connection of mother to child and child to mother.

The following is my understanding of this kind of 'interconnection' between the programs of our brain with the brain programs of other animals and their relation to facts and behaviour modes of lower species. We see for instance that man has a specific symbiotic relationship with microbes, which was already known in the case of coli bacteria. Unfortunately, we did not extend this understanding to other bacteria, since we regarded them as enemies.

If we take this relationship and attempt to correlate it with the mother child relationship, we see that a mother passes on to her child the antibodies to measles so that he will not develop it until after lactation which normally lasts three or four years. We also see that a mother gives her child tuberculosis bacteria in her milk, i.e. acid-resistant rod-shaped bacteria that do not damage the baby at all but are deposited for later use in its organism.

Scientists studying animal behaviour remind us (anthropologists having all but forgotten) that certain behaviour patterns in animals are innate and that others are acquired, and that these patterns are necessary equipment for every animal species.

It has always been the case for man and continues to be so, based on my examination of the biological conflicts. However, we now experience these conflicts in a quasi-civilized manner, one could almost say, in a paranoid manner. Investment shares can be experienced as a 'morsel' and we might react to their loss with a biological conflict. In nature, the paper on which the investment shares are printed would have been worthless.

When we lived in harmony with nature, our interactions with animals were regulated in a very natural form and manner.

We know from the fangs of our relatives the apes that they prey on small animals. At the same time, the apes themselves are prey for animals such as tigers and lions.

And so it was with man whose relationship with the animals is imprinted in his computer brain.

We see it still today when an embryo can become sick from the above-mentioned 'circular saw' syndrome: an embryo that cannot distinguish between the noise of a circular saw and the roaring of a lion suffers total panic as the mother passes close to a circular saw which may be cutting a branch. The embryo wants to get away, even though he is still not capable of running in the real sense. However, the evolutionary stage in which he finds himself suggests that he can move ahead in the phylogenetic sense. Or the embryo suffers the conflict of fear-of-separation when, anticipating an impending catastrophe, he feels he will end up far away from his family.

In the countryside today, the circular saw syndrome is the most frequent cause of motor and sensory paralysis in birth. This small example may be enough to illustrate how intimately we have been related to our fellow-creatures for millions of years and how, for the most part, animals are programmed into our computer brains.

If a dove suddenly drops to the ground upon seeing a shadow below it, we call it instinct, even though the dove has never seen a falcon because it's lived all its life in a

dovecote. The falcon is 'programmed' into the dove's brain and, although it has not been taught, the dove does the right thing immediately and instinctively. Basically, all animals follow their instinct; even their predators have their survival instincts pre-programmed into them.

The owl lays fewer eggs in spring if it feels there will not be enough mice; it will not decimate the mice and starve as a result.

These things are all wonderfully programmed in our brain and inter-connected with the programs of our fellow creatures.

The same is true between animals and plants, a biological equilibrium that survived marvellously for millions of years until man began to meddle. Of all the creatures on earth, it is only man who has lost his direction and disrupted the balance in this wondrous creation. Schiller's lines comes to mind:

„Dangerous to waken the lion
ruinous the tiger's tooth,
but the most fearsome calamity
is man in his insanity"

It is not my intention to be morose about the world's biological state, but instead to suggest that there is a need to find the lost paradise; not the one in which we were immortal, but the one in which we were in harmony with the rest of creation. W could attain harmony again by allowing our brain to react naturally to its millions-of-years-old-program.

It would take our brain a million years to account for the products of our civilization so dear to us. In a million years these will become old hat, as our brain can never keep up with the new discoveries. Instead of regarding this as a shortcoming, we should ask ourselves whether perhaps our discoveries cannot keep up with us and become integrated into the code of the brain.

The consequences of this for the individual, the family, the group, the village, the city or mankind as a whole still remain a completely different question. These questions should be debated and, with our knowledge of the New Medicine, an investigation into the behaviour of animals and plants along with the facts of evolutionary history should be considered. Only then could we rediscover a biologically liveable interconnected existence.

The world has probably not been in its present state of disorder for millions of years. It does not matter if the people who ask these questions are ridiculed as anti-civilization reactionary dreamers. The whole ecological movement (which belongs in this camp) was also ridiculed when it first started, until people finally paid it due respect.

Armed with the knowledge of these complex relationships, the doctor's main task in the medicine of the future will be to clarify to his patient the deeper meaning of his illness and to explain as closely as possible the natural resolution possibilities of his biological conflicts. Even here we have to ask if it will take a catastrophe before we begin to reflect on ourselves. We do not have to give up all our technological achievements to recover the million-year-old programming code of the brain and become one with ourselves again.

19 Biographical Details

Ryke Geerd Hamer, M.D. was born in 1935, and grew up in Frisia, Germany. He received his high school diploma at age 18 and began medical and theological studies in Tübingen, where he met Sigrid Oldenburg, a medical student, who later became his wife. At age 20, he passed the preliminary examination in medicine, married a year later in Erlangen and completed his theological examinations at 22. A daughter was born to the young family and a son, DIRK, who would later play a large role. At age 24, Dr. Hamer passed his medical state examination in Marburg. After his residency two years later, he was granted a professional licence as a doctor of medicine.

There followed a number of years at the university clinics of Tübingen and Heidelberg. In 1972, Dr. Hamer completed his specialization in internal medicine. He also worked in a practice with his wife Dr. Sigrid Hamer.

He had always had a specific hobby: patenting his inventions. Some examples are the non-traumatic Hamer-scalpel for plastic surgery that cuts twenty times more sharply than a razor; a special bone saw, also for plastic surgery; a massage table that automatically adjusts to the contours of the body; and a device for transcutaneous serum diagnosis.

Until August 1978, the Hamers were a completely normal family with four children (two girls and two boys). At 3 a.m. on August 18th, something terrible happened: a crazed Italian prince shot Dr. Hamer's son Dirk who was asleep on a boat anchored on the isle of Cavallo. With his father by his side day and night, Dirk's battle with death lasted almost four months. He died on December 7th, 1978. As became clear three years later, this resulted in a loss conflict for Dr. Hamer, causing a testicular carcinoma. He later named this conflict the 'Dirk Hamer Syndrome', a biological conflict shock that catches one unexpectedly 'on the wrong foot'.

In 1981, Dr. Hamer still thought these connections applied only to cancer and had no idea that the IRON RULE OF CANCER would become the central discovery for all of medicine. He submitted his discovery to the University of Tübingen in October 1981 as a post-doctoral thesis for qualification as a university lecturer. The main objective of the thesis was to provide a university with Dr. Hamer's results so that they could be tested on equivalent available cases as quickly as possible and for the benefit of the patients.

In May 1982 the university rejected the work on the interconnections between the psyche and cancer without testing a single case for reproduction, something they admitted to in court. The situation for the last thirteen years has remained the same, in that no university will carry out verification of Dr. Hamer's work.

Since the death of his son, Dr. Hamer claims that lawyers, agents, detectives and other emissaries of the House of Savoy have terrorized both him and his family.

In the following years, Dr. Hamer made repeated attempts to open a hospital or similar institution as a refuge for his patients and to enable them to benefit from his findings. Orchestrated action against this always made it impossible.

Mrs. Hamer died in 1985 from grief over the death of her son and demoralized by the constant fear created by the Savoy family. The persecution reached a high point in 1986 when the District of Koblenz commenced an action to prevent Dr. Hamer from practising medicine. This action succeeded because he literally refused 'to deny the Iron-Rule-of-Cancer and failed to convert to the tenets of official medicine'. This was accomplished in one hearing and re-affirmed in the subsequent hearing of 1990. Forcefully implemented, it was established that Dr. Hamer lacked 'manoeuvrability' and 'the necessary insight with regard to the required cancer therapy'.

Since 1986, Dr. Hamer has not been allowed to talk to any patients. A presiding judge of the District Court of Cologne advised him, by warrant, to find (at age 51) another calling unrelated to medicine.

This made it impossible for Dr. Hamer to continue scientific research. With no financial means, no secretary or assistants, he had to obtain CT's and corresponding records for his research with great difficulty through other doctors. He was unable to document all cases because the basic examinations pertinent to the investigations could not be carried out. Too much was left to chance. Had he had a clinic and some financial support, one can hardly imagine what would have happened.

In 1986 a court sentenced the University of Tübingen to continue the post-doctoral thesis proceedings. Nothing happened until January 3, 1994 when the judgment to validate Dr. Hamer's thesis was executed, a unique process in the history of universities! However, after 13 years, it was unlikely that the University of Tübingen would test the New Medicine on the equivalent cases. On April 22, the university announced „a verification within the framework of the post-doctoral thesis is not planned". (Readers who would like more current information regarding the events associated with the thesis may request documentation from the Amici di Dirk Publishers).

Dr. Hamer expanded his system in 1987 to 5 biological laws covering all diseases in the entire field of medicine, based on observation of 10,000 cases.

Since the underlying criteria are strictly scientific, it is very easy to check the New Medicine as it has been named since then. National and international physicians and physicians' associations are constantly testing it and verifying, through signed documentation, that it is correct.

20 References

Abel, Ulrich: Die zytostatische Chemotherapie fortgeschrittener epithelialer Tumoren. Stuttgart, 1990

Bahnson, C. B., Bahnson M. B.: Denial and Repression of Primitive Impulses and Disturbing Emotions in Patients with malignant Neoplasms. In: Psychosom. Aspects of Neoplastic Disease. Edited by D.M. Kissen and L.L.

Bräutigam, Walter und Christian, Paul: Psychosomatische Medizin Stuttgart 1973 und 1986

Documenta Geigy. wissenschaftlichen Tabellen, Basel 1960

Dontenwill, W. et al.: Untersuchungen über den Effekt der chronischen Zigarettenrauchinhalation beim syrischen Goldhamster und über die Bedeutung des Vitamin A auf die bei Berauchung gefundenen Organveränderungen, Zeitschrift f. Krebsforschung u. klin. Onkologie 89, 153-189, 1977.

Eibl-Eibesfeld, Irenäus: Der vorprogrammierte Mensch, Kiel 1985 ders.: Grundriß der vergleichenden Verhaltensforschung. ders.: Ethologie, München 1980 ders.: Menschenforschung auf neuen Wegen, Wien 1976

Engel,GL.:Selection of Clinical Material in Psychosomatic Medicine. The Need for a New Pysiology. Psychosom. Med. 1954,16:368-373.

Evans,E.: A Psychological Study of Cancer. New York, Dodd, Mead & Co., Inc. 1926, 226 pp.

Evans R.B. et al.: Some Psychological Characteristics of Men Cancer. Cancer 1964,17:307-313.

Global Cancerology: New York 1986

Greene, W.A. jr., Young L. E., Swisher S.N.: Psychological Factors and Reticuloendothelial Disease. II. Obsevation on a Group of Women with Lymphomas and Leukemias. Psychosom. Med. 1956, 18: 284-303.

Greene, W. A. jr.: Psychological Factors and Reticuloendothelial Disease. I. Preliminary Observation on a Group of Males with Lymphomas and leukemias. Psychosom. Med. 1954,16: 220-230.

Grossart-Maticek, Ronald: Krankheit als Biographie, Köln 1979 Klinische Onkologie (hrsg. UICC), Berlin 1982

Kretschmann, Hans-Joachim und Weinrich, Wolfgang: Klinische Neuroanatomie und kranielle Bilddiagnostik, Stuttgart 1991

LeShan. Pitman Medical Publishing Co. Ltd., 1964, p. 42-62. ders. Laurence: Psychotherapie gegen den Krebs, Stuttgart 1993

Liedloff, Jean: Auf der Suche nach dem verlorenen Glück, München 1988

Lorenz, Konrad: Verhaltensforschung, Wien 1978 ders.: über tierisches und menschliches Verhalten, Leck 1968.

Mech. L.David: Der weiße Wolf, München 1994 ders.:Auf der Fährte der Wölfe, München 1991

Meerwein, Fritz: Einführung in die Psycho-Onkologie, Bern 1981 und 1991 Moore, Keith L.: Embryologie, Stuttgart 1985

Müller, H.E.: Die Infektionserreger des Menschen, Berlin 1989 Munk, Anders: Biologie des menschlichen Verhalten, Stuttgart 1972 Neumayr, A. and Weiss, W.: Liver tumors - new aspects, Hepatogastroenterology 28.1., 1981

Rohwedder, Cl.: Dissertaions, Statistische Untersuchung über Bronchial-Karzinom, Hamburg 1978

Simonton, C.O.: Getting well again, L.A., 1978

Simonton, C.O.u. Matthews-Simonton, St. u. Creighton, J.: Wieder Gesund werden, Hamburg 1993;
Spektrum der Wissenschaft: Krebs-Tumoren, Zellen, Gene, Heidelberg 1990
Thompson, Richard F.: Das Gehirn, Heidelberg 1992
Uexküll, v. Th.: Grundfragen der psychosomatischen Medizin, Hamburg, 1963 ders.: Psychosomatische Medizin, München, 1990
ders. u. Wesiack: Theorie der Humanmedizin, München 1988
Warell, D.: Lehrb. der Infektionskrank. 1990, Artikel v. Citron und Girling

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